

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6151 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06039

FOR STATE HEALTH DEPT

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Washington		c. LENGTH OF STAY IN TB Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac River				d. STREET ADDRESS 520 13th Street S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter James Anderson		First Middle Last		4. DATE OF DEATH May 5 1960		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 24, 1937		9. AGE (In years last birthday) 23		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Delivery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter Scott Anderson				14. MOTHER'S MAIDEN NAME Grace Hilderbrand			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-48-5743		17. INFORMANT Address Mrs Grace Grvlik, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Drowning DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Jumped from a sinking boat into the river					
20c. TIME OF INJURY Month, Day, Year 12:15 a.m. 5/7 1960		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Fort Washington P. G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/6/60	
22a. BURIAL TRANSIT PERMIT NO. (Type) 5/7/60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		22d. LOCATION (City, town, or country) (State) Colmore Manor, Md.	
23. FUNERAL DIRECTOR ADDRESS J.Wm. Lee's Sons Co. 300-4th St. N.E.				24a. REC'D BY REGISTRAR MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6090

CERTIFICATE OF DEATH

06040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights d. STREET ADDRESS 5400 Shadyside Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle H. Last Ashford				4. DATE OF DEATH Month MAY Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 11, 1880	
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months 0 Days 0		11. UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY Print Shop		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry G. Ashford				14. MOTHER'S MAIDEN NAME Emma (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Unknown		Address Caroline Weadon, 5400 Shadyside Ave. Suitland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalomalacia DUE TO (c) Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emaciation							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 13, 1960 , to May 17, 1960 , that I last saw the deceased alive on May 17, 1960 , and that death occurred at 9:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George H. Nageage				ADDRESS (Street, city or town, state) 3717--38th Street, Cottage City, Md.			
DATE SIGNED 5/17/1960							
PHYSICIAN'S NAME (Type) DR. G. NAGEAGE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 19th, 1960		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, 517--11th St. S.E. Wash. DC				24a. REC'D BY REGISTRAR MAY 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

UNITED STATES

DEPARTMENT OF JUSTICE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6152

CERTIFICATE OF DEATH

Reg. Dist. No.

06041

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 month and 20 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1013 V St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha - Ayers		4. DATE OF DEATH Month Day Year 5 26 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/99
9. AGE (In years lost birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator	11. BIRTHPLACE (State or foreign country) S. Carolina
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Dave Myrick	
14. MOTHER'S MAIDEN NAME Henrietta ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 240-10-1355		INFORMANT Decedent	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 442X IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease with cardiomegaly and myocardial insufficiency; cervical adenitis, tuberculous		INTERVAL BETWEEN ONSET AND DEATH Unknown	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 015X	
20c. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 4/6/ 19 60 , to 5/26/ 19 60 , that I last saw the deceased alive on 5/26/ 19 60 , and that death occurred at 3:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 5/26/60 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5/26/60	
22c. NAME OF CEMETERY OR CREMATORY Washington, D. C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Johnson - Johnson ADDRESS 4804 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR DATE 5-2 MAY 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. REGISTRAR'S SIGNATURE	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

29. ANDERSON, J. W. 1980. *Journal of Fish Biology* 16: 1-10.

— *Journal of the American Medical Association*

121:50

0-11-000-000

6091

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5802 40th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Jerome Barrett		4. DATE OF DEATH Month May Day 18 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 12, 1880		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood, Fine + Metal Rattner		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Ashville, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Young, Deceased		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 578-10-0664		INFORMANT Nola Lee Barrett, Wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the colon DUE TO (c) Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 10, 19 60 , to May 18, 19 60 , that I last saw the deceased alive on May 18, 19 60 , and that death occurred at 8:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5102 Annapolis Rd., Bladensburg, Md.		DATE SIGNED 3/8/8/60	
ACTUAL SIGNATURE Julius Kauffman		PHYSICIAN'S NAME (Type) Dr. Julius Kauffman, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md		23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.	
24a. REC'D BY REGISTRAR MAY 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25. I certify that I attended the deceased from May 10, 19 60 , to May 18, 19 60 , that I last saw the deceased alive on May 18, 19 60 , and that death occurred at 8:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5102 Annapolis Rd., Bladensburg, Md.		DATE SIGNED 3/8/8/60		26. I certify that I attended the deceased from May 10, 19 60 , to May 18, 19 60 , that I last saw the deceased alive on May 18, 19 60 , and that death occurred at 8:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5102 Annapolis Rd., Bladensburg, Md.	

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Handwritten notes and text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some legible fragments include:

- Top left: "1000"
- Top center: "CENTRAL"
- Top right: "1000"
- Middle left: "1000"
- Middle center: "1000"
- Middle right: "1000"
- Bottom left: "1000"
- Bottom center: "1000"
- Bottom right: "1000"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6144

CERTIFICATE OF DEATH

Reg. Dist. No.

06043

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Landover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Beland Memorial Hosp.</u>		d. STREET ADDRESS <u>Landover Road</u>	
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Baxter</u> Middle <u>Baxter</u> Last		4. DATE OF DEATH <u>May</u> Month <u>28</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-95</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas P. Baxter</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>.</u>	
17. INFORMANT <u>Hosp. records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Failure</u> 527-1 DUE TO <u>Chronic Pulmonary Emphysema years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary Emphysema years</u> (c) <u>Chronic Pulmonary Emphysema years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-26</u> , 19 <u>60</u> to <u>5-27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>60</u> , and that death occurred at <u>1:15 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy B. Parsons</u> M.D.		ADDRESS (Street, city or town, state) <u>Burtons ville, Md.</u> DATE SIGNED <u>May 28, 1960</u>	
PHYSICIAN'S NAME (Type) <u>Roy B Parsons Jr</u>		<u>Burtons ville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons</u> ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>JUN 2 1960</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

6153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b. 5 months and 24 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3200 17th St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sam Middle L. Last Billings		4. DATE OF DEATH Month 5 Day 19 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/92
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Gus' Barber Shop	
11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bill Billings		14. MOTHER'S MAIDEN NAME Josephine Oshields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown -		16. SOCIAL SECURITY NO. 227-05-7162	
17. INFORMANT Decedent		18. ADDRESS Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active (1 yr., 8 months); pulmonary emphysema and fibrosis; coronary atherosclerosis.		INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 002X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/25/59 , to 5/19/60 , that I last saw the deceased alive on 5/19/60 , and that death occurred at 8:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 5/19/60 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5-20-60	
22c. NAME OF CEMETERY OR CREMATORY Union S. C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hall's Funeral Home Int. Rainier Md		24a. REC'D BY REGISTRAR MAY 23 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Deceased

Age

Sex

Place of Birth

Place of Death

Occupation

Color

Religion

Marital Status

Cause of Death

Time of Death

Place of Burial

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Witness

Filed for Record

Recorded and Indexed

This certificate is subject to the provisions of the laws of the State of Texas relating to the collection and use of vital statistics.

Witness my hand and seal this

day of

19

at the City of

County of

State of Texas

My Commission Expires

Notary Public

My Commission Expires

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6073

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 61 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3504 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marie Bohnert		4. DATE OF DEATH 5-- 1 --- 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Bohnert		14. MOTHER'S MAIDEN NAME Theresa Lamp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address George Bohnert; Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia 561.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Strangulated umbilical hernia (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED May 2, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Son's 4739 Balt. Ave. Hyattsville, Md.		24a. REC'D BY REGISTRAR MAY 6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX Male		RACE White		DATE OF BIRTH 10-14-1928		PLACE OF BIRTH MOBILE, ALA.	
OCCUPATION None		MARITAL STATUS Single		EDUCATION High School		RELIGION Catholic		US CITIZENSHIP Yes	
PRESENT ADDRESS 1015 N. W. 10th St., Miami, Fla.		HOME PHONE None		BUSINESS PHONE None		DATE OF DEATH 4-4-68		TIME OF DEATH 11:00 AM	
CAUSE OF DEATH Asphyxiation by gunshot wound		MANNER OF DEATH Homicide		PLACE OF DEATH Room 309, Motel 6, Miami, Fla.		MEDICAL HISTORY None		SURGICAL HISTORY None	
PRE-EXISTING DISEASES None		MEDICATIONS None		ALLERGIC REACTIONS None		TOBACCO USE None		ALCOHOL USE None	
SIGNATURE OF EXAMINER J. Edgar Hoover		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF CORONER None		SIGNATURE OF JURY None	

ENCLOSURE

6154

CERTIFICATE OF DEATH

Reg. Dist. No.

06046

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>B</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SUITLAND</u>				c. LENGTH OF STAY IN 1b <u>2 1/4 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u> <u>47X3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUITLAND NURSING HOME</u>				d. STREET ADDRESS <u>3612 GUSTIN ST. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES E. BOSSERMAN</u>				4. DATE OF DEATH Month Day Year <u>MAY 5 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 13 1898</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUS DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSIT</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JAMES E. BOSSERMAN</u>				14. MOTHER'S MAIDEN NAME <u>Ilda B. Orbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>				16. SOCIAL SECURITY NO. <u>578-10-7228</u>		INFORMANT Address <u>NURSING HOME CHART INF BY DAUGHTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 MON.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/27/</u> , 19 <u>60</u> , to <u>present</u> , 19____, that I last saw the deceased alive on <u>April 4</u> , 19 <u>60</u> , and that death occurred at <u>8:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Stanley J. Talpers</u> M.D. <u>1025 Vermont Ave. NW</u> PHYSICIAN'S NAME (Type) <u>STANLEY J. TALPERS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. 517-11th St. S.E.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06047

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery POTTERS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 1557-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 5608 Albia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joanna Middle Teresa Last Bray				4. DATE OF DEATH Month May Day 15 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-10	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 15 Days 15		IF UNDER 24 HRS. Hours 19 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY U. of Md.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph R. Bray				14. MOTHER'S MAIDEN NAME Mildred Gottlieb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Joseph R. Bray; same address as # 2		17. INFORMANT Address Joseph R. Bray; same address as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.6 DUE TO Drowning Conditions, if any, which gave rise to immediate cause (b) Syncope (c), stating the underlying cause lost. DUE TO Concussion of brain stem							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Struck head while taking shower, lost consciousness and drowned.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck head while taking shower, lost consciousness and drowned.					
20c. TIME OF INJURY Month, Day, Year 5-15 19 60		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) University		20f. (City or town) (County) (State) College Park Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 15, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Hate of Heaven Cem		22d. LOCATION (City, town, or county) (State) Wheaton Md	
23. FUNERAL DIRECTOR'S SIGNATURE H. Don. Wilson				ADDRESS 2224 Wisc Ave NW Wash DC		24a. REC'D BY REGISTRAR DATE MAY 27 '60	
						24b. REGISTRAR'S SIGNATURE Robert S. Kline	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

57

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1900	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
JAN 20 1940		HOME		10:00 AM		98.6	
SIGNATURE OF EXAMINER		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1940		10:00 AM	
SIGNATURE OF WITNESS		TITLE		DATE		TIME	
J. H. HARRIS		LABORER		JAN 20 1940		10:00 AM	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06048

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 5314 Patterson Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gerard Middle Augustus Last Britton			4. DATE OF DEATH Month May Day 14 , Year 19 60		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-16-34 1933	9. AGE (In years last ^{yr} ₇₁) 27 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Defense		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Marshall T. Britton		
14. MOTHER'S MAIDEN NAME ELE Eulalia Lechleitner			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes U.S. Army		
16. SOCIAL SECURITY NO. 578-42-7518		17. INFORMANT Address Nancy A. Britton; same address as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbonmonoxide poisoning (c) Carbonmonoxide poisoning DUE TO cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Overcome by smoke while fighting a fire.			
20c. TIME OF INJURY Month, Day, Year 11:00 p.m. 5-11-60 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	
20f. (City or town) Edmonston		(County) Pr. Geo.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED May 15, 1960		
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 5/17/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington,		(State) Va.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons	
4739 Baltimore Avenue Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE 5-18-60		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

51



6093

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Christina Middle Brooks Last Brooks				4. DATE OF DEATH Month May Day 2 Year 19 60			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Jan. 1960	
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Thomas A Brooks				14. MOTHER'S MAIDEN NAME Pearl Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Thomas A Brooks Address Brandywine Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral necrosis (cause 332X) DUE TO undetermined - awaiting microscopic examination. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) examination. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atelectasis INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1960 , to May 2, 1960 , that I last saw the deceased alive on May 2, 1960 , and that death occurred at 7:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamlet St., Hyattsville Md.			
PHYSICIAN'S NAME (Type) Dr. John Perkins M.D.				DATE SIGNED 5/2/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-60		22c. NAME OF CEMETERY OR CREMATORY St. Philips		22d. LOCATION (City, town, or county) (State) Aguasco P. G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Nelson				24a. REC'D BY REGISTRAR DATE MAY 4 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Hunt							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06050

6076

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 68 Berwyn Heights			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville, Convalescent Home				f. STREET ADDRESS 8512 60th Avenue				
3. NAME OF DECEASED (Type or print) Ellen Brooks				4. DATE OF DEATH Month May Day 15 Year 19 60				
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 3, 1890		9. AGE (in years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Smith Van Keurn				14. MOTHER'S MAIDEN NAME Coburn				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Genevieve Glenkoski; same address as # 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (c) 443X DUE TO (c) 443X DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL, etc. Transportation		22b. DATE THEREOF May 16, 1960		22c. NAME OF CEMETERY OR CREMATORY Allegan		22d. LOCATION (City, town, or county) (State) Michigan		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR MAY 17 '60		
						24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kane</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH JAN 15 1962		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. OCCUPATION Retired		8. MARITAL STATUS Married		9. EDUCATION High School	
10. BIRTH DATE JAN 15 1897		11. BIRTH PLACE Baltimore, Md.		12. RACE White	
13. PRESENT ADDRESS 1234 Main St., Baltimore, Md.		14. US. CITIZENSHIP Naturalized		15. SOCIAL SECURITY NO. 1-234-56789	
16. DECEASED'S SIGNATURE <i>James H. Harris</i>		17. SIGNATURE OF MEDICAL EXAMINER <i>John D. Smith</i>		18. SIGNATURE OF WITNESS <i>John D. Smith</i>	
19. CAUSE OF DEATH Heart Disease		20. MANNER OF DEATH Natural		21. OTHER CAUSE OF DEATH None	
22. MEDICAL HISTORY Hypertension, Diabetes		23. PRESENT ILLNESS Myocardial Infarction		24. TREATMENT Medication	
25. POSTMORTEM EXAMINATION None		26. ORGAN DONOR No		27. ORGAN DONOR No	
28. SIGNATURE OF MEDICAL EXAMINER <i>John D. Smith</i>		29. SIGNATURE OF WITNESS <i>John D. Smith</i>		30. SIGNATURE OF WITNESS <i>John D. Smith</i>	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06051

6077

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 1953	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1904 Charlston Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle BROWN Last BROWN		4. DATE OF DEATH Month MAY Day 14 Year 1960	
5. SEX F	6. COLOR OR RACE wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-'68
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engineering	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Long		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Fred R Edwards Hyattsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to 1960 , that I last saw the deceased alive on May 14, 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin M. Grassgreen M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3101 ARUNDEL RD MT. RAINIER, MD	
PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN M.D.		Mt Rainier Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE - MAY 16 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kane	

58

6155

CERTIFICATE OF DEATH

06052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 628 Eye St., S. E.	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Bruff		4. DATE OF DEATH Month Day Year 5 18 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Heurich Brewery	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmett Bruff		14. MOTHER'S MAIDEN NAME Anna O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-7410	
17. INFORMANT Dedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Far advanced pulmonary tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right upper lobectomy, 6/57; right thoracoplasty, 6/57; right broncho-pleural fistula			INTERVAL BETWEEN ONSET AND DEATH 1 month 9 yrs., 3 mos.
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/28/ 19 51 , to 5/18/ 19 60 , that I last saw the deceased alive on 5/18/ 19 60 , and that death occurred at 3:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 5/18/60 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/21/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Wash, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
ADDRESS 517 11th ST SE		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH



1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

6094

CERTIFICATE OF DEATH

06053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr George.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lee Onan Bryant				4. DATE OF DEATH May 6 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1889	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Office City				10b. KIND OF BUSINESS OR INDUSTRY Retired			
13. FATHER'S NAME Charles H Bryant				14. MOTHER'S MAIDEN NAME Suana Spicknall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. Daisy Bryant - same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - recurrent DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO 10 yrs (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 hr							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1956 to May 1960 , that I last saw the deceased alive on 5/2 1960 , and that death occurred at 10:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M. Trozzo Jr.				ADDRESS (Street, city or town, state) 3501 Hamilton St. Hgt 5/7/60			
PHYSICIAN'S NAME (Type) FRANK M. TROZZO JR				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-10-60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lewis				ADDRESS Wash. D. C.			
24a. REC'D BY REGISTRAR MAY 10 1960				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7004

CERTIFICATE OF DEATH

14023

Prince George

Prince George General

Lee

Quay

Bryant

May 6

40

male

white

March 7, 1889

VI

Post Office City

Resided

Maryland

U.S.

Charles B Bryant

Emma Saltsman

Daisy Bryant - same as above

Informant: Harry P. Bryant

3201

5-10-40

Post Office City

Residence

Wm. D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 14, Film G-263, 5/19/60.cac.

6156

CERTIFICATE OF DEATH

06054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Skyline				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6007. Reamy. Dr				d. STREET ADDRESS 836. Taylor. St N E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ruth E Burdette				4. DATE OF DEATH Month Day Year May 7th 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17. 1873		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington. D C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Thomas E. Johnson				14. MOTHER'S MAIDEN NAME Mary Ann Hamlin Howlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Edna M. Burdette 836. Taylor St N E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 59 , to May 7 , 19 60 , that I last saw the deceased alive on May 5 , 19 60 , and that death occurred at 8:03 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis Parker				ADDRESS (Street, city or town, state) 5241 St. Bonifacio Rd			
DATE SIGNED 5/7/60							
PHYSICIAN'S NAME (Type) Lewis Parker							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5.11.1960		Congresional		Washington D C	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home				ADDRESS 300. 4th st N E.		24a. REC'D BY REGISTRAR DATE MAY 12 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6157
 CERTIFICATE OF DEATH

06055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL LAUREL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>ARTHUR</u> Last <u>BURNHAM</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 2 1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BURNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK FACTORY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WALTER ELLSWORTH BURNHAM</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE GILLEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Wife see #2</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized carcinomatosis</u> <u>183X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leiomyosarcoma lung</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>May 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>60</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Buell</u>				ADDRESS (Street, city or town, state) <u>402 Main St Laurel Md</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>				DATE SIGNED <u>5/7/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 10, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Calmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson, Laurel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. K.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

Reg. Dist. No.

6095

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Lanham		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7701 Cross Street			
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Harrison Callison				4. DATE OF DEATH Month Day Year May 11 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-1889	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coalminer		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Briggs Callison				14. MOTHER'S MAIDEN NAME Jane OsbornE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-07-4811		17. INFORMANT Address Lawrence Callison; Carrollton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO (o), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-60		22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR DATE MAY 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06057

6158

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>DANVILLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORAL HILLS</u>		c. LENGTH OF STAY IN 1b <u>4 MOS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5709 R St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SANTA</u> Middle <u>MATTON</u> Last <u>CARDELL</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GIUSEPPE MATTONE</u>		14. MOTHER'S MAIDEN NAME <u>ANNINA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>5709 R ST CORAL HILLS</u>	
17. INFORMANT <u>YOLANDA CASALE</u>		Address <u>5709 R ST CORAL HILLS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR, METASTATIC</u> DUE TO <u>192.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTASES</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 MOS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>3</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>60</u> , to <u>MAY</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 28</u> , 19 <u>60</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond J. Terrafrauca</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>8 Con BARNEY CIRCLE SE MAY 30 1960</u>	
PHYSICIAN'S NAME (Type) <u>RAYMOND J TERRAFRAUCA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-1-60</u>	<u>Highland Cem</u>	<u>Danville Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deer Funeral Home 4812 R. Ave N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 7 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is filled out with handwritten text.

NAME: [Handwritten Name]
AGE: [Handwritten Age]
SEX: [Handwritten Sex]
RACE: [Handwritten Race]
DATE OF DEATH: [Handwritten Date]
CAUSE OF DEATH: [Handwritten Cause of Death]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06058

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 05 Mitchellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pool of water near Pope's Creek R.R.				/d. STREET ADDRESS Old Stage Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Wayne Coleman				4. DATE OF DEATH May 26 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-55	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard G. Coleman, Sr.				14. MOTHER'S MAIDEN NAME Doris Ickes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Doris Coleman; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) Drowning (c) DUE TO c. stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in stagnant pool of water.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5-26- 19 60 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pool of water		20f. (City or town) Mitchellville, Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

16

2

pp

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

50

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John Doe		Male		45		1910-01-01	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St, Baltimore, MD		Teacher		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER	
1950-03-15		Home		10:00 AM		[Signature]	
FAMILY PHYSICIAN		HOSPITAL		CORONER		MEDICAL EXAMINER	
Dr. Smith		St. Mary's		John Doe		[Signature]	
FAMILY PHYSICIAN'S ADDRESS		HOSPITAL'S ADDRESS		CORONER'S ADDRESS		MEDICAL EXAMINER'S ADDRESS	
456 Oak St, Baltimore, MD		123 Main St, Baltimore, MD		123 Main St, Baltimore, MD		123 Main St, Baltimore, MD	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06059

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 05 Mitchellville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pool of water near Pope's Creek R.R.				d. STREET ADDRESS Old Stage Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Gordon Last Coleman, Jr.				4. DATE OF DEATH Month May Day 26 Year 1960			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-54		9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard G. Coleman, Sr.				14. MOTHER'S MAIDEN NAME Doris Ickes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Doris Coleman; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned in stagnant pool of water.					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5 p. m. 26 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pool of water		20f. (City or town) (County) (State) Mitchellville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> May 27, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/60		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR MAY 31 '60	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6096

CERTIFICATE OF DEATH

Item 11 Film 0263 5-19-60 et - 6265 - 4/16/60 - 28

06060

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARTIN First TIMOTHY Middle COONAN Last				4. DATE OF DEATH Month May Day 13 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 19, 1960		9. AGE (In years last birthday) yrs. 24	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 24 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND, Prince Georges	
12. CITIZEN OF WHAT COUNTRY? none				13. FATHER'S NAME Walter Philip Coonan			
14. MOTHER'S MAIDEN NAME Leona Rought				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Mrs. Marie C. Waldmann - 407 Compton Ave. Laurel Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart disease DUE TO (c) terminal atherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) terminal atherosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 4/19 1960 , to May 13, 1960 , that (I) (we) last saw the deceased alive on 5/12 1960 , and that death occurred at 4 AM, from the causes and on the date stated above.			
22a. SIGNATURE [Signature]				22b. DATE SIGNED 5/13/60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 5/11/60			
23c. NAME OF CEMETERY OR CREMATORY New Freedom Cemetery				23d. LOCATION (City, town, or county) (State) New Freedom, Penna.			
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR May 16 '60			
25b. REGISTRAR'S SIGNATURE [Signature]				25c. REGISTRAR'S NAME Arthur S. Hines			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06061

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5402 Cleveland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marcel Middle Cordove Last Cordove Male Negro 5. SEX 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 23, 1903 9. AGE (in years last birthday) 56 yrs. 10. IF UNDER 1 YEAR 25 Months 25 Days 19 Hours 60 Min.				4. DATE OF DEATH Month May Day 25 Year 1960 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 10b. KIND OF BUSINESS OR INDUSTRY Automobile				13. FATHER'S NAME Marcelino Cordove 14. MOTHER'S MAIDEN NAME Mary Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 17. INFORMANT Marie Sands Sister Address 5402 Cleveland Avenue				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Acute Pericarditis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 23, 1960 to May 25, 1960 that (I) (we) lost saw the deceased alive on May 25, 1960 , and that death occurred at 1:50 P.M. from the causes and on the date stated above. 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR DATE JUN 1 '60 25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1907

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Director,
page 1 should be detached for use as the burial-transit permit. Then please remove coroner's register, and in any event, within 72 hours after death, file with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland / Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4910 Lackwanna St	
3. NAME OF DECEASED (Type or print) Helen First Middle Last Curtin		4. DATE OF DEATH Month Day Year May 28 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 10, 1915
9. AGE (In years (last birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENN.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE STROH	
14. MOTHER'S MAIDEN NAME ANNA McLAUGHLIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT JOHN CURTIN Address AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 INRHOSIS OF LIVER			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/26/60 2:45p to May 28 , 1960, that (I) (we) last saw the deceased alive on 5/28 , 19 60 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Norman Donat Comeau		22b. DATE SIGNED 5/28/60	
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		22d. ADDRESS 3503 PERRY ST MT RAINIER MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6/1/60	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET	23d. LOCATION (City, town, or county) (State) WASH. D. C.
24. FUNERAL DIRECTOR'S SIGNATURE Emmett Taylor - 3831-GA. AVE. NW		25a. REC'D BY REGISTRAR JUN 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

(M)

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6098

CERTIFICATE OF BIRTH

MASSACHUSETTS DEPARTMENT OF HEALTH

THE REGISTRAR OF VITALS

Birth Date

Gender

Place of Birth

Home

Parents

Child

Age

Signature of Registrar

Date

6099

CERTIFICATE OF DEATH

06062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Washington 21			
f. STREET ADDRESS 7218 E Fortfoot Terr S.E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Julia L Davis				4. DATE OF DEATH Month May Day 21 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 18 Dec. 1885	
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Bailey				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT C. Edward Davis				Address 4212- Westmoreland St. McLean Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 Bunch pneumonia DUE TO (b) Trypan blue carcinoma DUE TO (c) 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/27 , 19 60 , to 5/21 , 19 60 , that I last saw the deceased alive on 5/20 , 19 60 , and that death occurred at 3:15 AM from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 1229-37 ST NW Wash DC							
DATE SIGNED							
ACTUAL SIGNATURE Jeanner C. Bateman							
M.D. Dr. Bateman., M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF May 23rd. 60							
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery							
22d. LOCATION (City, town, or county) (State) Suitland, Maryland.							
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros							
ADDRESS 1661 1st Hope Rd. SE							
24a. REC'D BY REGISTRAR May 24 '60							
24b. REGISTRAR'S SIGNATURE Arthur L. Kious							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6100

CERTIFICATE OF DEATH

06063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 65 Riverdale	
f. STREET ADDRESS 4701 Ravenwood Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle ROSE Last Doerr		4. DATE OF DEATH Month May Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1899
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM WARTH.		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT HAROLD E.C. DOERR		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive arterio-sclerotic heart DUE TO Cong Heart failure disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hemorrhagic pancreatitis		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to MAY 21, 1960 , that I last saw the deceased alive on MAY 20, 1960 , and that death occurred at 12, 20A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Fred. Musser M.D.		ADDRESS (Street, city or town, state) 4410 7th Ave S.E. 5th/160 DATE SIGNED 5/21/60	
PHYSICIAN'S NAME (Type) Dr. Fred. Musser M.D.		LOCATION (City, town, or county) (State) Landover Hills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-24-1960	
22c. NAME OF CEMETERY OR CREMATORY Wash. National		22d. LOCATION (City, town, or county) (State) W. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Maryland		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

00003

CERTIFICATE OF DEATH

1900

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

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Place of Birth

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6078
CERTIFICATE OF DEATH

110064
06064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>6 yrs. 60</u> <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5606 Queens Chapel Rd</u>		d. STREET ADDRESS <u>5606 Queens Chapel Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph DANIEL DOOLEY</u>		4. DATE OF DEATH Month Day Year <u>MAY 14 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST RETIRED U.S. Navy Yard</u>		11. BIRTHPLACE (State or foreign country) <u>MOBILE, ALA BAMA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSEPH R. DOOLEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA T. NEINREITHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WIFE</u> Address <u>Mrs Bessie M. Dooley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>MAY 14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MAY 14</u> , 19 <u>60</u> , and that death occurred at <u>6⁰⁰ P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Borneau</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Perry St</u> DATE SIGNED <u>5/14/60</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT BORNEAU</u>		<u>MT. RAINIER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

1003

STATE OF TEXAS

County of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6079

CERTIFICATE OF DEATH

06065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5353 Quiney Place</u>		d. STREET ADDRESS <u>5353 Quiney Place</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNE</u> Middle <u>Louise</u> Last <u>Eagle</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4, 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Stores</u>	
11. BIRTHPLACE (State or foreign country) <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Meeks</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Trammell Rollins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-16-825</u>	
17. INFORMANT <u>George L. Eagle</u>		Address <u>Same as 2A</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>58</u> , to <u>May 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>60</u> , and that death occurred at <u>12:15</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William D. Rosson</u> M.D.			
PHYSICIAN'S NAME (Type) <u>William A. Rosson</u> <u>5304 Annapolis Rd. Bladensburg Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>May 28, 1960</u>	<u>Armon Chapel</u>	<u>Forestville, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u> ADDRESS <u>5801 Cleveland Ave. Riverdale, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

CERTIFICATE OF DEATH

1973

43

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is partially filled out with handwritten text.

NAME: *John Doe*

DATE: *10/15/73*

TIME: *10:00 AM*

PLACE: *Home*

CAUSE OF DEATH: *Heart Disease*

... (faint text) ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6161

CERTIFICATE OF DEATH

Reg. Dist. No.

06066

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1003 Lincoln Pl., S.E.	
3. NAME OF DECEASED (Type or print) First Felix Middle - Last Edwards		4. DATE OF DEATH Month May Day 14 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1900
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. unk.	
INFORMANT Person (Patient very ill on admission)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Bronchopneumonia, acute, right lung, etiology undetermined DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, with chronic organic brain syndrome; old cerebrovascular accident with right spastic residuals.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24, 19 60, to 5/14, 19 60, that I last saw the deceased alive on 5/14, 19 60, and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED 5/14/60	
PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		Glenn Dale Hospital Glenn Dale, Maryland	
22a. BURIAL CREMATION, REMOVA (Specify) 5/15/61		22b. DATE THEREOF 5/15/61	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Morris A. Anty...		24a. REC'D BY REGISTRAR DATE MAY 17 '60	
ADDRESS 306-H, St. N.W.		24b. REGISTRAR'S SIGNATURE Arthur S. H...	

CERTIFICATE OF NATURALIZATION

1911

UNITED STATES DEPARTMENT OF JUSTICE
IMMIGRATION AND NATURALIZATION SERVICE
WASHINGTON, D. C.
In testimony whereof, I have hereunto set my hand and the seal of the Department of Justice at Washington, D. C., this 1st day of May, 1911.
J. Edgar Hoover, Director
The following is a true and correct copy of the original certificate of naturalization of the within named individual, as the same appears in the records of the Immigration and Naturalization Service, at Washington, D. C., and is certified to be correct by the Director of the said Service.
J. Edgar Hoover, Director
The following is a true and correct copy of the original certificate of naturalization of the within named individual, as the same appears in the records of the Immigration and Naturalization Service, at Washington, D. C., and is certified to be correct by the Director of the said Service.
J. Edgar Hoover, Director

6162

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Naylor				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Box 3588				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Wilson Fenno				4. DATE OF DEATH Month Day Year May 17, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1873	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Harrison Fenno				14. MOTHER'S MAIDEN NAME Sarah Weaver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Harry H. Fenno -Same as above.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 arteriosclerosis - generalized severe DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1958, to <u>12 May</u> , 1960, that I last saw the deceased alive on <u>16 May</u> , 1960, and that death occurred at <u>1</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Upper Marlboro, Maryland 5/18/60 ACTUAL SIGNATURE Robert B. Sasscer M.D. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/19/60		22c. NAME OF CEMETERY OR CREMATORY Brookfield Cemetery		22d. LOCATION (City, town, or county) (State) Naylor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Funeral Home - Upper Marlboro, Md.				24a. REC'D BY REGISTRAR MAY 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN THE COURT OF THE COMMON PLEAS

1883

IN SENATE,
January 17, 1883.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1882.
ALBANY:
J. B. LEECH, PRINTER,
1883.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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06068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 7/ College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7320 Baylor Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Mayberry Flynn		4. DATE OF DEATH Month Day Year May 28, 1960 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 13, 1879
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Building contractor	
11. BIRTHPLACE (State or foreign country) Newark New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Flynn		14. MOTHER'S MAIDEN NAME Mary Mayberry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no -		16. SOCIAL SECURITY NO. no -	
17. INFORMANT Robert M Lynn College Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Carcinoma of the Prostate DUE TO (b) with metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
21. I certify that I attended the deceased from May 28, 1960, to May 28, 1960, that I last saw the deceased alive on May 28, 1960, and that death occurred at 10:30 A.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Ronald S. Fleischer, M.D.		DATE SIGNED 5/28/60	
PHYSICIAN'S NAME (Type) Ronald S. Fleischer, M.D.		5432 Queens Chapel Rd., Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1960	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Wheaton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24. REC'D BY REGISTRAR DATE MAY 31 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

7

6101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Fronck		4. DATE OF DEATH Month May Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 May 1960
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months 6 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Erick Franck		14. MOTHER'S MAIDEN NAME Donna Lee Raley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature Separation of the Placenta DUE TO (c) Placenta Previa (Central)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 60 , to May 1 , 19 60 , that I last saw the deceased alive on May 1 , 19 60 , and that death occurred at 10:52 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William C. Weintraub		ADDRESS (Street, city or town, state) 9E Parkway	
PHYSICIAN'S NAME (Type) Dr. Weintraub., M.D.		DATE SIGNED 5-2-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/20/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

06070

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale		c. LENGTH OF STAY IN lb 1 yr., 7 Mo., & Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 days Glenn Dale Hospital		d. STREET ADDRESS 518 6th St., S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Josephine E. Fulwood		4. DATE OF DEATH Month Day Year May 29 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Legally Separated <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1925
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry worker		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) St. Paul, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddeus Walters		14. MOTHER'S MAIDEN NAME Harriett Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Person		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage 002X DUE TO Post-operative, Right upper lobectomy and wedge resection of the superior segment, right lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (b) 5 days DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis, Active, 3 yrs., 1 mo.; Left upper lobectomy 12/16/59			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 6, 1958, to May 29, 1960, that I last saw the deceased alive on May 29, 1960, and that death occurred at 7:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Moe Weiss		DATE SIGNED May 29, 1960	
PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		Glenn Dale, Md.	
22a. DATE OF REMOVAL (Specify) 5/30/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 26

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• *For more information, call 1-800-368-2767.*

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Prince Georges

YES ☐ NO ☐

Day	Year
25	19

Months	Days	Hours	Min.
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Decedent

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19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

ADDRESS (Street, city or town, state)

DATE SIGNED _____

Glenn Dale Hospital

5/25/60

Moe Weiss, M. D.

Glenn Dale, Md.

22d. LOCATION (City, town, or county)

(State

24b. REGISTRAR'S SIGNATURE

DATE MAY 31 '60

Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06072

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Princes Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle B. Last Gahan				4. DATE OF DEATH Month May Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1880		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Entomologist				10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. of Agric. Research		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME James Gahan				14. MOTHER'S MAIDEN NAME Elizabeth James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Emily B. Gahan Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Intracerebral hemorrhage DUE TO (b) Arteriosclerosis DUE TO (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 22, 1960 to May 22, 1960 , that (I) (we) last saw the deceased alive on May 22, 1960 , and that death occurred at 5:23-1960 M, from the causes and on the date stated above.							
22a. SIGNATURE Hans Wodak				22b. DATE SIGNED 5-23-1960		22c. PHYSICIAN'S NAME (Type) Hans Wodak	
22d. ADDRESS Greenbelt, Md.							
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 5/26/60		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Harsh's Sons				25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 3 Film G263 5-24-60 et
CERTIFICATE OF DEATH

06074

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges= MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION General Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irving Middle Golladay Last Theodore L. Golladay		4. DATE OF DEATH Month May Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Feb 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer- Pure Opr.		10b. KIND OF BUSINESS OR INDUSTRY Store Packer	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David J. Golladay		14. MOTHER'S MAIDEN NAME Bertie L. Golladay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-26-8600	
17. INFORMANT Mrs Selma Golladay		2501 57th. Ave. Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 CONGESTIVE HEART FAILURE DUE TO ARTEURYSM LEFT VENTRICLE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 44ms DUE TO ARTERIOSCLEROTIC HEART DISEASE (c) 7yrs		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to MAY 18 1960 , that I last saw the deceased alive on MAY 18 1960 , and that death occurred at 2,30A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Dink Comeau M.D. 3503 PENNY ST		ADDRESS (Street, city or town, state) 5/18/60	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.		Mt. Rainier., Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Church		22d. LOCATION (City, town, or county) (State) New Market, Virginia	
23. BY W. Dellinger & Son ADDRESS Woodstock, Va.		24a. REC'D BY REGISTRAR MAY 23 1960	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

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Prince William

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill, Maryland				c. LENGTH OF STAY IN 1b 35- Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 5320- St. Barnabas Road S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE L. GRAY				4. DATE OF DEATH Month May Day 7th. Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2- 1888		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elias Gray				14. MOTHER'S MAIDEN NAME Emma Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Mrs. Katherine L. Gray		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) DUE TO (c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 , 19 59 , to 5 , 19 60 , that I last saw the deceased alive on 5-9- , 19 60 , and that death occurred at 3:00 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis Parker		M.D. 5241 St. Barnabas Rd. 5/9/60 ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) L. Lewis Parker		5214- St. Barnabas Road S.E.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 9- 1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros		ADDRESS 1661- Good Hope Road S.E. Washington 20, D.C.		24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06076

6080

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 4 mos. 22 das		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bell's Nursing Home				d. STREET ADDRESS 4408 Beach Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle ANN Last HABIB				4. DATE OF DEATH Month MAY Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1959	
9. AGE (In years lost birthday) 0 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Moe Habib				14. MOTHER'S MAIDEN NAME Helen Joseph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Moe Habib		Address Item 2 - above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hydrocephalus (internal) 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Corporal	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 12/17 , 1959, to 5/22 , 1960, that I last saw the deceased alive on 5/22 , 1960, and that death occurred at 8:55 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Park Maryland DATE SIGNED 5/23/60							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				22a. REGISTRAR'S SIGNATURE Thomas A. Christensen			
22b. DATE THEREOF 5-26-60				22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			
22d. LOCATION (City, town, or county) Arlington, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi				24a. REC'D BY REGISTRAR DATE MAY 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
24c. ADDRESS 816 H St., NE, Wash. 2, DC							

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1. 2. 3.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6104 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06077
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Hyattsville			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7116 Country Club Court			
3. NAME OF DECEASED (Type or print) First Lawrence Middle Winfield Last Haney				4. DATE OF DEATH Month May Day 22 Year 1960			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1923		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Plywood warehouse		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Miller Haney				14. MOTHER'S MAIDEN NAME Mable Lawrence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.2 198-18-1662		17. INFORMANT Address Janet E. Haney; same address as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		May 22, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/60		22c. NAME OF CEMETERY OR CREMATORY George Washington		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE MAY 25 '60	
						24b. REGISTRAR'S SIGNATURE Colman S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

24

6167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b & 13 days 7 mos.		d. STREET ADDRESS 900 9th St., S. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruby Middle May Last Havens		4. DATE OF DEATH Month 5 Day 19 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/2/98
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY Lewis Hotel Training School	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Henry Northey		14. MOTHER'S MAIDEN NAME Mary Lu King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917 - 1918 579-12-9888	
17. INFORMANT Decedent		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage 002X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) Pulmonary tuberculosis, far advanced, active DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 23 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/6/ , 19 58 , to 5/19/ , 19 60 , that I last saw the deceased alive on 5/19/ , 19 60 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Moe Weiss	DATE SIGNED 5/19/60
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
ADDRESS (Street, city or town, state) Glenn Dale Hospital, Glenn Dale, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/60	22c. NAME OF CEMETERY OR CREMATORY Burial Home	22d. LOCATION (City, town, or county) (State) Burial Home, Fairfax, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thoma		24a. REC'D BY REGISTRAR DATE MAY 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

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Registration

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(Date) 1913

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6168

CERTIFICATE OF DEATH

06079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Shenandoah			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Lanham, Md.				c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Jackson Va	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7716 Garrison Road				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Johnson Last Hawkins				4. DATE OF DEATH Month May Day 15 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Mt Jackson Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Roy J Hawkins				14. MOTHER'S MAIDEN NAME Mary Arthur Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Charles Hawkins Address West Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung. 163X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/18/1952 to 5/15/1960 , that I last saw the deceased alive on 5/13/1960 , and that death occurred at 6:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) 4410 74th Ave		DATE SIGNED 5/15/60	
PHYSICIAN'S NAME (Type) F. E. Musser				Bellemeade Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt Jackson Cemetery		22d. LOCATION (City, town, or county) (State) Mt Jackson Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE MAY 16 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6169

CERTIFICATE OF DEATH

Reg. Dist. No.

06080

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA 08X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS HAWTHORNE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATTIE Middle BELLE Last HAYDEN				4. DATE OF DEATH Month MAY Day 9 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE CA4		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 August 1906	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RYCEVILLE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Samuel W. Ryce				14. MOTHER'S MAIDEN NAME Mary E. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no				16. SOCIAL SECURITY NO. None			
17. INFORMANT Philip Hayden, La Plata, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of colon & metastases 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5 MAY , 19 60 , to 9 May , 19 60 , that I last saw the deceased alive on 9 May , 19 60 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William C. Segmiller, M.D. USAF Hosp Andrews 9 May 60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) William C. Segmiller Andrews AFB, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-13-60		22c. NAME OF CEMETERY OR CREMATORY Holy Ghost		22d. LOCATION (City, town, or county) (State) Issue, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAY 17 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

10000

CERTIFICATE OF DEATH

8100

WILLIAM C. ZEDMITER

CERTIFICATE OF DEATH

Reg. Dist. No.

6105

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park	
c. LENGTH OF STAY IN 1b 2 hr.		d. STREET ADDRESS 306-65 th. St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Otha Middle Hinkle Last May		4. DATE OF DEATH Month May Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 19, 1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Pulaski, Ky.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James M. Hinkle		14. MOTHER'S MAIDEN NAME Verna Harmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 287-09-2125	
17. INFORMANT Eugene Smith		Address 1112-St Margaret's Dr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 12, 1960 to May 16, 1960 that I last saw the deceased alive on May 22, 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainerd		ADDRESS (Street, city or town, state) 6124 Central Ave M.D.	
PHYSICIAN'S NAME (Type) Dr. William Brainerd		DATE SIGNED 5/22/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25/60	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR 300-4th St SE	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris		DATE MAY 25 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

72

(1)

1102

Private Secretary

Secretary

3 m.

Original text

Sub-2-10-101

Private Secretary

200

Home

Nov 19, 1924

State Office

2-10-101

Wanda M. White

Wanda M. White

Private Secretary

Private Secretary

Private Secretary

22 20

12-10-101

Private Secretary

12-10-101

Reg. Dist. No.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY		Pr. Geo.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		47		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mount Rainier					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3800 - 30th. street		d. STREET ADDRESS		3800 - 30th. street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
EULYSSES				HOGE				May		18		1960	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/18/1878		81 yrs.		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Repairman		Typewriters		Philadelphia, Pa.		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Lindley M. Hoge		Martha C. Smith											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address							
No				Lillian P. Hoge (Same as above)									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420-1		DUE TO		Generalized Arteriosclerosis and		5 years		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO		(c)		Common Heart Disease				3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 11-9, 1956, to 5-18, 1960 that I last saw the deceased alive on 5-15, 1960, and that death occurred at 9:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED									
ACTUAL SIGNATURE		Waldo B. Moyers		M.D.		3503 Petty St		5-19-60					
PHYSICIAN'S NAME (Type)		Waldo B. Moyers		Mt. Rainier Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)					
Burial		5/21/1960		Fort Lincoln Cemetery		Colmar Manor, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Nalley's Funeral Home Inc.		3200-R.I. AVE. Mt. Rainier Md.		DATE MAY 23 '60		Arthur S. Hays							

47

1

CERTIFICATE OF DEATH

0082

Pr. Dec.

Kerryland

Mount Rainier

Mr. Rainier

3000 - 30th Street

3000 - 30th Street

BOOK

BUSSA

10/18/1946

Male

Philadelphia, Pa. U.S.A.

Typewriter

Houseman

Martha G. Smith

Linnet M. Hoge

William F. Hoge (Same as above)

No

6170

CERTIFICATE OF DEATH

Reg. Dist. No.

06083

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2 months & 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1615 D. St., S. E.	
3. NAME OF DECEASED (Type or print) First Samuel Middle B. Last Holmes		4. DATE OF DEATH Month 5 Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/98
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Spotlight	
11. BIRTHPLACE (State or foreign country) 3100 R.I. Island, N.E. S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Holmes		14. MOTHER'S MAIDEN NAME Mary Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-07-5083?	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic squamous cell carcinoma of larynx (epiglottis) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 161X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left cervical esophagostomy, 5/5/60			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9/1960 to 5/18/1960 , that I last saw the deceased alive on 5/18/1960 , and that death occurred at 5:10A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 5/18/60 ACTUAL SIGNATURE Moë Weiss M.D. PHYSICIAN'S NAME (Type) Moë Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/19/60	
22c. NAME OF CEMETERY OR CREMATORY D. C. Morgue		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Glenn Dale Hosp., Glenn Dale, Md.		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6170

DATE OF DEATH

1900

DEATH STATE OF NEW YORK

1. Name of deceased
2. Age
3. Sex
4. Color
5. Occupation
6. Cause of death
7. Date of death
8. Place of death
9. Signature of physician
10. Signature of coroner
11. Signature of witness
12. Signature of registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6106

CERTIFICATE OF DEATH

06084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Hopkins Last Hopkins		4. DATE OF DEATH Month May Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 24, 1960
9. AGE (In years lost birthday) yrs. 14		10. IF UNDER 1 YEAR Months 14	
11. IF UNDER 24 HRS. Days 14 Hours 14 Min. 14		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Novel Hopkins		14. MOTHER'S MAIDEN NAME Nellie Gaye Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis DUE TO (c) Intestinal obstruction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 24 , 19 60 , May 9 , 19 60 , May 9 , 19 60 , that I last saw the deceased alive on May 9 , 19 60 , and that death occurred at 12:55A , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 6905 Baltimore Ave., College Park, Md.			
DATE SIGNED May 9, 1960			
ACTUAL SIGNATURE Thomas A. Christensen		M.D. 6905 Baltimore Ave., College Park, Md.	
PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.		22. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/19/60	
22c. LOCATION (City, town, or county) (State) Cheverly, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR May 24 '60	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

31

1

W. J. [unclear]
[unclear]
[unclear]

6171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 39 DAYS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD (DISTRICT OF COLUMBIA)				b. COUNTY P. 600															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First LIZZETTA				Middle JANE				Last HOULE				4. DATE OF DEATH Month MAY				Day 22				Year 1960											
5. SEX FEMALE				6. COLOR OR RACE CAUCASIAN				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 22 AUGUST 1888				9. AGE (In years last birthday) 71 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical								10b. KIND OF BUSINESS OR INDUSTRY Internal Revenue								11. BIRTHPLACE (State or foreign country) MONTANA								12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME HANS HAGENSON												14. MOTHER'S MAIDEN NAME MARY OLSON																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO								16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A								17. INFORMANT Lt Col F. E. Roth								Address Same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Renal obstruction, bilateral (c) Papillary cystadenocarcinoma, ovary, widespread																INTERVAL BETWEEN ONSET AND DEATH 1 week 2 week															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 APRIL, 19 60, to 22 MAY, 19 60, that I last saw the deceased alive on 22 May, 19 60, and that death occurred at 2:10 PM, from the causes and on the date stated above.																															
ACTUAL SIGNATURE George E. Randall												ADDRESS (Street, city or town, state) USAF Hospital Andrews												DATE SIGNED 22 May 60							
PHYSICIAN'S NAME (Type) GEORGE E. RANDALL, CAPT, USAF, MC												ANDREWS AIR FORCE BASE, WASH 25, D.C.																			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal								22b. DATE THEREOF 5/24/60								22c. NAME OF CEMETERY OR CREMATORY								22d. LOCATION (City, town, or county) Helena, Montana							
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.																24a. REC'D BY REGISTRAR DATE MAY 26 '60								24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

6171

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF REPORT

SIGNATURE

DATE

1

1

John Doe

1234 Main St

City, State

Age

Sex

Occupation

Marital Status

Signature

Date

Signature

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06086

6107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Wise			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 48 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Castlewood Rural			
3. NAME OF DECEASED (Type or print) First Minnie Middle D Last Howard				4. DATE OF DEATH Month May Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 12, 1889		9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Flintwood, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Preston Fleming				14. MOTHER'S MAIDEN NAME Victoria Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Yes-Unknown		INFORMANT Daughter Address Mrs. Kenneth Jones-811 5th. St, NW Wash, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis of coronary arteries DUE TO Advanced Gen. atherosclerosis (c) Advanced Gen. atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cheverly; P. Georges Ind.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 1 , 19 60 , to May 18 , 19 60 that I last saw the deceased alive on May 18 , 19 60 , and that death occurred at 11:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr J De Rubins		M.D. Prince George Hospital		DATE SIGNED 5/18/60			
PHYSICIAN'S NAME (Type) Dr J De Rubins							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-19-1960		22c. NAME OF CEMETERY Holbrook Family		22d. LOCATION (City, town, or county) (State) Castlewood, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan Inc ADDRESS 317 Pq One SE				24a. REC'D BY REGISTRAR MAY 20 1960		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

Wife

Virginia

Charlottesville

18 days

Overly

Princess George General Hospital

Howard

D

Princess

Female - White

Jan 12, 1982

Princess George, Virginia

Housewife

John Prancer Fleming

Virginia Taylor

Princess

100-Unknown Mrs. Kenneth Jones - 111 2nd St. N.W. Wash. DC

C

May 12

1980

Apr. 1

May 18

1980

Princess George General Hospital

Overly, Md.

Dr. J. De Haven

Charlottesville, Virginia

Princess George Family

5-17-1980

Princess

6139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jair MOUNT-HGTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Jair MOUNT-HGTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>704-60 AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John D.</u> Middle <u>Jackson</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>73</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Highway Wash. D.C.</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>
13. FATHER'S NAME <u>Andrew Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Susan - ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PEPTIC ULCER</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>59</u> , to <u>5-18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>60</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. C. Beldan</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>44-23-HUNT-PI-NE 5-18-60</u>	
PHYSICIAN'S NAME (Type) <u>H. C. Beldan, MD, Washington - 19 - D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Stewart</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 23 '60</u>	
ADDRESS <u>30 H Street, N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the paper to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6108

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sadie Jenkins				4. DATE OF DEATH May 6 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-1900	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) S. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A							
13. FATHER'S NAME Mal Hiers				14. MOTHER'S MAIDEN NAME Mary Boatright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. INFORMANT Address Herbert Jenkins - 6221 Lee Pl.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO Nephrosclerosis (c) Nephrosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from MAY 2, 1960 , to MAY 6, 1960 , that I last saw the deceased alive on MAY 6, 1960 , and that death occurred at 3:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles C. Hageage				M.D. MT. RAINIER			
PHYSICIAN'S NAME (Type) DR CHARLES HAGEAGE				M.D. MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
5-11-60		Mat. Harmony		Shurff Rd Spt Ind			
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 4925 Reane Ave NE			
24a. REC'D BY REGISTRAR MAY 11 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6103

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06090

6145

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 70 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 8800 Baltimore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERIK H. JOHNSON		4. DATE OF DEATH Month May Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 05 9604	
17. INFORMANT Hospital Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-28 , 19 60 , to 5-5 , 19 60 , that I last saw the deceased alive on 5-5 , 19 60 , and that death occurred at 12:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R. B. Parsons, Jr. M.D. PHYSICIAN'S NAME (Type) R. B. Parsons, Jr., M.D., 4404 Queensbury Road, Riverdale, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MAY 29 1960
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 7 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR 4922 Lindell Rd.</u>				d. STREET ADDRESS <u>50-31 st St. N. W</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>V.</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-12-1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTERS ASSIST.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUREAU OF PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George Jones</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Kennedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Sister Mary Agnes Patricia 4922 Lindell Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombo-cytopenic Purpura</u> <u>290.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Megaloblastic Anemia</u> DUE TO (c) <u>Generalized Arterio-sclerosis</u> <u>Undetermined</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephro-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>6 mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1948</u> to <u>May 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>May 28, 1960</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>May 29, 1960</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>June 1, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	
23d. LOCATION (City, town, or county) <u>WASH. DC</u>				(State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Tattouell</u>				ADDRESS <u>3603 14th St NW</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

100001

CENTRAL OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Now 6/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6148

6147

CERTIFICATE OF DEATH

Reg. Dist. No.

06092

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN 1b 5 hrs.		d. STREET ADDRESS Box 126	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Kaiser Last Kaiser		4. DATE OF DEATH Month May Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1960
9. AGE (In years lost birthday) 5 yrs.		IF UNDER 1 YEAR: Months 5 Days 20 Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Lee Kaiser		14. MOTHER'S MAIDEN NAME Maomi Rebecca Carr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Perinatal asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Asphyxia (c) DUE TO Asphyxia		INTERVAL BETWEEN ONSET AND DEATH 2 hr post Asphyxia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. j. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15 , 19 60 , to 5/15 , 19 60 , that I last saw the deceased alive on 5/15 , 19 60 , and that death occurred at 12:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Robert O. Hynes M.D. Robert O. Hynes			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY Long Hill Cem		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE De Witt Caralston		24a. REC'D BY REGISTRAR DATE MAY 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

2076172XV1

6109

CERTIFICATE OF DEATH

06093
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 1/2 Da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle L. Last Kassner				4. DATE OF DEATH Month May Day 19 Year 19 60			
5. SEX Female		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-10	
9. AGE (In years last birthday) 49 yrs.		10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Joseph Tippet				14. MOTHER'S MAIDEN NAME Sarah Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) X No				16. SOCIAL SECURITY NO. INFORMANT Joseph J. Kassner Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1 CONGESTIVE HEART FAILURE & CVA DUE TO (b) METASTATIC INFILTRATION DUE TO (c) CHRONIC MYELOGENOUS LEUKEMIA							INTERVAL BETWEEN ONSET AND DEATH 5/10-5/19 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/10 , 19 60 , to 5/19 , 19 60 , that I last saw the deceased alive on 5/19 , 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Max M. Herzberg				ADDRESS (Street, city or town, state) 7016 Greg St., Seat Pleasant, Md. DATE SIGNED 5/19/60			
PHYSICIAN'S NAME (Type) Dr. Max Herzberg M.D.				M.D. 7016 Greg St., Seat Pleasant, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Harcho's Sons				4737 Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Harris			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

28

6172

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN lb 9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION 6650 TEMPLE HILLS RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORA CATHERINE KENNEY		4. DATE OF DEATH Month Day Year MAY 25 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 4-1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC KREGLO		14. MOTHER'S MAIDEN NAME MARY D'GROFF	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ROBERT KENNEY-SON -		Address 6650 TEMPLE HILLS RD CLINTON	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE (c) MULTIPLE MYELOMA		INTERVAL BETWEEN ONSET AND DEATH 6 days 10 days 2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHO-PNEUMONIA 2 WKS. BEFORE DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. None		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> None	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 17 , 19 60 , to Present , that I last saw the deceased alive on MAY 23 , 19 60 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver Jr.		DATE SIGNED MAY 25 1960	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		ADDRESS (Street, city or town, state) BRANCH AVE. CLINTON, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 28-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Sutton MD
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		24a. REC'D BY REGISTRAR 1661- Wood Hope rd SE WA SA 20 PC	
24b. REGISTRAR'S SIGNATURE Arthur S. House		DATE MAY 26 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5718

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06095
Reg. Dist. No.

6110

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 17 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6267 Rawlings Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last King				4. DATE OF DEATH Month May Day 8 Year 19 60			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-09		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chester Johnson				14. MOTHER'S MAIDEN NAME Nannie Watson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Lillian Posey; 4704 Brooks St., N.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Compression DUE TO 900,0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sub-dural hemorrhage DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stairs					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home of son		20f. (City or town) (County) (State) Washington, D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-13-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Not Harmony Park		22d. LOCATION (City, town, or county) (State) Shoriff Rd Ext Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				24a. REC'D BY REGISTRAR MAY 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Carmody Hills-Seat Pleasant</u>		d. STREET ADDRESS <u>418 Carmody Hills Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> , Year <u>19 60</u>															
3. NAME OF DECEASED (Type or print) <u>Clifford</u>		First <u>Clifford</u> Middle <u>Kirby</u> Last <u>Kirby</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-06</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cableman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.E.P.Co.</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Kirby</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Lee Simms</u>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-09-3502</u>				17. INFORMANT <u>Marie Kirby; same address</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <u>John T. Maloney</u>				EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>May 22, 1960</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/23/60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				<u>4739 Baltimore Avenue</u> <u>Hyattsville, Maryland</u>				24a. REC'D BY REGISTRAR <u>MAY 24 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Clifford L. Thomas</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in writing the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		45		1900		Maryland		Baltimore		Maryland		United States	
MARRIAGE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY			
MARRIED		MARRIED		1925		Baltimore		Maryland		Maryland		United States			
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
Physician		Physician		Physician		Physician		Physician		Physician		Physician		Physician	
EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION		EDUCATION	
High School		High School		High School		High School		High School		High School		High School		High School	
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		RELIGION	
Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic		Roman Catholic	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death		Manner of Death	
Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner		Signature of Medical Examiner	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
Date		Date		Date		Date		Date		Date		Date		Date	
1950		1950		1950		1950		1950		1950		1950		1950	

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1

CHILDREN, TWENTY TWO YEARS OF AGE, ONE DAUGHTER, ONE SON, BOTH LIVING, BOTH IN THE UNITED STATES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6173 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> c. LENGTH OF STAY IN lb <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4800 N Street SE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u> d. STREET ADDRESS <u>4800 N Street SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Catherine Lanham</u>				4. DATE OF DEATH Month Day Year <u>May 6 1960</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>				11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Fred Weil</u>						14. MOTHER'S MAIDEN NAME <u>Emma Schlenker</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Edwin C Lanham 6100 N St SE Hillside</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgar Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Smithland, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>						ADDRESS <u>1661-94 Hope Rd SE</u>				24a. REC'D BY REGISTRAR <u>May 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH—BARTMORE 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>63 Edmonston</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4805 48th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>La Prad</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3-29-34</u>		9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Millard F. Lewis</u>			
14. MOTHER'S MAIDEN NAME <u>Beatrice B. Sanders</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>			
16. SOCIAL SECURITY NO. <u>No.</u>				17. INFORMANT <u>Choy D. LaPrad; same address as # 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Gunshot wound of head</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted wound.</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>1.45</u> Min. <u>PM</u> <u>5-2-60</u> 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Edmonston</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 4, 1960</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>MAY 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06099

6174

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	c. LENGTH OF STAY IN 1b 6 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5503 Griffith Drive		d. STREET ADDRESS 5503-Griffith Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Gertrude First Middle Last Farmer		4. DATE OF DEATH May 31 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1919
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Morris Prosserman	
14. MOTHER'S MAIDEN NAME DORA GRUBNICK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 186-05-7485		17. INFORMANT Ralph E. Farmer, Somerset #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9774X asphyxia DUE TO (b) Hanging Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Hanged self from ceiling of room	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5-31 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Camp Springs (County) P.S. (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James D. F. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5-31-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-3-60	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Inc. 517-11th St. N.E.		24a. REC'D BY REGISTRAR DATE JUN 3 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Fraus

MEDICAL CERTIFICATION

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06100

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/ Hyattsville d. STREET ADDRESS 6102-20th. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Zella Leach		4. DATE OF DEATH Month May Day 22 Year 60	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 5, 1901	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min. 10	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13. FATHER'S NAME GEORGE T. WOOD		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyper tension Arterio-sclerotic DUE TO heart disease (c) heart disease		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1959 to May 21, 1960 , that I last saw the deceased alive on May 22, 1960 , and that death occurred at 10:40 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5432 Queens Chapel Rd Hyattsville Md DATE SIGNED 5/21/60	
ACTUAL SIGNATURE W. W. Chambers M.D.		PHYSICIAN'S NAME (Type) Dr. Fleischer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 5-27-1960	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers co. Riverdale Md		24. REG'D. BY REGISTRAR DATE MAY 27 60	
24b. REGISTRAR'S SIGNATURE William S. Harts			

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THE NATIONAL ARCHIVES

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U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D.C. 20250

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SALVADOR STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G262 5/12/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

06101

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie First S Middle Lee Last		4. DATE OF DEATH May Month 4 Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-07
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Kline		14. MOTHER'S MAIDEN NAME Fannie Spitzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address Edward M. Shaw-Bro.-in-law	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aneurysm of abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 4 60 , to May 4 60 , that I last saw the deceased alive on May 4 60 , and that death occurred at 3:30 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cottage City, Md. DATE SIGNED May 5, 1960	
ACTUAL SIGNATURE George Hageage M.D. 3717 38th Ave.		PHYSICIAN'S NAME (Type) Dr. George Hageage, M.D.	
22a. BURIAL, CREMATION, REMOVAL, etc. 5/7/60		22b. DATE THEREOF 5/7/60	
22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cem		22d. LOCATION (City, town, or county) (State) Hearndon, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. LEE ADDRESS 300 4th St NE		24a. REC'D BY REGISTRAR MAY 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CLASSIFICATION

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6140

CERTIFICATE OF DEATH

06102
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairmount Heights</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>30 Fairmount Heights</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>715-59" Ave.</i>				d. STREET ADDRESS <i>1 715-59" Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Delia</i> First <i>LEWIS</i> Middle Last				4. DATE OF DEATH <i>May 8</i> 19 <i>60</i> Year			
5. SEX <i>fe</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 7, 1879</i>	
9. AGE (In years last birthday) <i>80</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Gadsden Co., Fla.</i>		11. BIRTHPLACE (State or foreign country) <i>WIS. A.</i>	
13. FATHER'S NAME <i>Tom Sweet</i>				14. MOTHER'S MAIDEN NAME <i>Patsie Ellis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>Joseph W. Lewis</i> Address <i>715-59" Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.2</i> DUE TO <i>Left Ventricular Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>underlying</i> DUE TO (c) <i>underlying</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Natural Causes of Age</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> to <i>May 8</i> 19 <i>60</i> , that I last saw the deceased alive on <i>May 7</i> 19 <i>60</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John W. Robinson</i>				ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. NE 5/8/60</i>			
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i>				WASHINGTON D.C.			
22a. BURIAL, CREMATION, REMAINS (City)		22b. DATE THEREOF <i>5-13-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>WOODLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>MORROW & WOODFORD, INC.</i>				ADDRESS <i>1622-11th, st. N.W.</i>		24a. REC'D BY REGISTRAR <i>MAY 12 '60</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6115

CERTIFICATE OF DEATH

Reg. Dist. No. 103

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nettie Middle Lewis Last Lewis		4. DATE OF DEATH Month 21 Day May Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Dec. 1893
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Fulton, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Charles Pierpont		14. MOTHER'S MAIDEN NAME Georgianna Isabella Cross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLI DUE TO 411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AORTIC STENOSIS DUE TO RHEUMATIC HEART DISEASE (c) 10yrs		INTERVAL BETWEEN ONSET AND DEATH 3wks 5yrs 10yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/19 , 19 60 , to 5/21 , 19 60 , that I last saw the deceased alive on 5/21 , 19 60 , and that death occurred at 1, 20AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman D. Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Elm St. Mt. Rainier, Md. DATE SIGNED 5/21/60	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.		Mt. Rainier, Md.	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY St Paul Cemetery		22d. LOCATION (City, town, or county) (State) Fulton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Connelley, Laurel, Md.		24. REC'D BY REGISTRAR MAY 25 '60 24b. REGISTRAR'S SIGNATURE C. P. L. Haines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6116

CERTIFICATE OF DEATH

Reg. Dist. No.

06104

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 1/2 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Boy Middle (Timothy Wade) Last Lewis				4. DATE OF DEATH Month May Day 4 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-60	
9. AGE (In years lost birthday) 1 1/2 Hrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Floyd Lewis				14. MOTHER'S MAIDEN NAME Geraldine Anne Mourean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Address Mother Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Prematurity DUE TO (b) Atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 4 , 19 60 , to May 4 , 19 60 , that I last saw the deceased alive on 5-4-60 , 19 60 , and that death occurred at 10:35 pm from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 6901 Baltimore Ave. DATE SIGNED 5/6/60							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 5/19/60			
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital				22d. LOCATION (City, town, or county) (State) Cheverly, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				24a. REC'D BY REGISTRAR DATE MAY 24 '60			
24b. REGISTRAR'S SIGNATURE Charles S. Harris							

MEDICAL CERTIFICATION

1

2077211XV10

7



1-1-0

DATE: 1-1-0

TIME: 1-1-0

PLACE: 1-1-0

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06105

6082

Item 14 Film G264 6-7-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balt. & Ohio R.R. Tracks		d. STREET ADDRESS 3911 Rhode Island Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Pace Last Lipscomb		4. DATE OF DEATH Month May Day 25 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-14
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46	IF UNDER 24 HRS. Hours 46 Min. 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10b. KIND OF BUSINESS OR INDUSTRY Glass tile cutting	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Pace Lipscomb		14. MOTHER'S MAIDEN NAME Polly Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Margaret Lipscomb; same address as # 2.	
17. INFORMANT Margaret Lipscomb; same address as # 2.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Crushed head, chest and pelvis, multiple fractures of arms and legs. DUE TO (c) Struck by train		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by a train of the B & O Railroad Co.	
20c. TIME OF INJURY Month, Day, Year 4.53 p.m. 5-25-1960		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks		20f. (City or town) (County) (State) Hyattsville, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 25, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1960	
22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR JUN 2 '60	
ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the file. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

46

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [REDACTED]
2. SEX: [REDACTED]
3. AGE: [REDACTED]
4. DATE OF BIRTH: [REDACTED]
5. PLACE OF BIRTH: [REDACTED]
6. OCCUPATION: [REDACTED]
7. CAUSE OF DEATH: [REDACTED]
8. MANNER OF DEATH: [REDACTED]
9. SIGNATURE OF EXAMINER: [REDACTED]
10. DATE OF EXAMINATION: [REDACTED]

CERTIFICATE OF DEATH

Reg. Dist. No.

06106

6142

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NORTH CAROLINA b. COUNTY 70X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN TB adm. Aug 8 - 1951 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHEVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) LAUREL SANITARIUM		d. STREET ADDRESS 2	
3. NAME OF DECEASED (Type or print) Bridget First M Middle L Last LOMINAC		4. DATE OF DEATH Month MAY Day 15 Year 1960	
5. SEX female	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11 - 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IRELAND	12. CITIZEN OF WHAT COUNTRY? unknown
13. FATHER'S NAME DENIS McQUILLAN		14. MOTHER'S MAIDEN NAME BRIDGET COLEMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral arteriosclerosis (c) with psychotic reaction		INTERVAL BETWEEN ONSET AND DEATH 12 days many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 56 to May 15 , 1960, that I last saw the deceased alive on May 15 , 19 60 , and that death occurred at 850 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Inda P. Kraemer M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 5-15-1960	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial-transit	5-16-60	Riverside Cemetery	Ashville, North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR MAY 17 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraemer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OFFICE

CENTRAL OFFICE OF THE ARMY

1918

TO THE SECRETARY OF THE ARMY
FROM THE CHIEF OF THE BUREAU OF MILITARY INTELLIGENCE
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly discussing military intelligence matters.]

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6175 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 FilmG263 5-31-60 et

06107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Muirkirk		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore and Ohio Rail Road tracks		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Claggett Smith Longest		4. DATE OF DEATH Month May Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Golden Longest		14. MOTHER'S MAIDEN NAME Priscilla Jackson Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1	
17. INFORMANT Maude B. Wilson; 1933 Wilkins Ave., Balt. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock 800 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed skull, chest and pelvis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by train of B & O Railroad	
20c. TIME OF INJURY Month, Day, Year 5.10 Hour PM 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad tracks		20f. (City or town) (County) (State) Muirkirk Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED May 21, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-60	
22c. NAME OF CEMETERY OR CREMATORY St. Stephens Ch. Ceme.		22d. LOCATION (City, town, or county) (State) Kenn + Queen Co. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Baschis Sons		24a. REC'D BY REGISTRAR Hyattsville Md	
24b. REGISTRAR'S SIGNATURE Arthur S. Huns		DATE MAY 24 '60	

<p>NAME OF DECEASED: <u>JOHN J. BROWN</u></p>		<p>AGE: <u>45</u></p>	
<p>RESIDENCE: <u>123 Main St., Boston, Mass.</u></p>		<p>DATE OF DEATH: <u>Jan 15, 1920</u></p>	
<p>CAUSE OF DEATH: <u>Myocardial Infarction</u></p>		<p>PLACE OF DEATH: <u>Home</u></p>	
<p>TIME OF DEATH: <u>10:30 AM</u></p>		<p>SEX: <u>Male</u></p>	
<p>DATE OF BIRTH: <u>Jan 1, 1875</u></p>		<p>HEIGHT: <u>5' 8"</u></p>	
<p>WEIGHT: <u>175 lbs</u></p>		<p>TEMPERATURE: <u>98.6</u></p>	
<p>PULSE: <u>60</u></p>		<p>BLOOD PRESSURE: <u>120/80</u></p>	
<p>DIAGNOSIS: <u>Myocardial Infarction</u></p>		<p>POST-MORTEM: <u>No</u></p>	
<p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>DATE: <u>Jan 15, 1920</u></p>	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18
6176 Item 9 Film G263 5-20-60 et
CERTIFICATE OF DEATH

06108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X 3	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 121 Ingraham Pk. NW.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 904 64th Ave NE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KATE Longwood		4. DATE OF DEATH Month Day Year 5-15-1960	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Larson Jefferson (see)		14. MOTHER'S MAIDEN NAME Namie (see)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Georgia Gaines		Address 121 Ingraham Pk. NW.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 to 6 3/4	
PARTIAL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease; Cerebral Arteriosclerosis.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 30, 1950, to May 15, 1960, that I last saw the deceased alive on 5/14/60, and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. MARQUE		DATE SIGNED 5-15-60	
PHYSICIAN'S NAME (Type) E. C. MARQUE		ADDRESS (Street, city or town, state) 1801 9th St. NW, Wash. D.C.	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5-20-60	22c. NAME OF CEMETERY OR CREMATORY Salem Baptist	22d. LOCATION (City, town, or county) (State) King George Co. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews 3619-14 "St. N.W. Wash.		24a. REC'D BY REGISTRAR DATE MAY 17 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

CERTIFICATE OF DEATH

06109

Reg. Dist. No.

6117

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elmer				4. DATE OF DEATH May 14 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 6 89 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Last Postmaster		10b. KIND OF BUSINESS OR INDUSTRY US Govt		11. BIRTH PLACE (State or foreign country) Laurel, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winfield Scott Mallance				14. MOTHER'S MAIDEN NAME Althea Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-32-9784A			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilatation of Heart 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes melitus, 7 yrs Chronic prostatitis 2 Yrs				INTERVAL BETWEEN ONSET AND DEATH 1 day 18 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 50 to May 14 , 19 60 that I last saw the deceased alive on May 14 , 19 60 , and that death occurred at 10:30P from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Robert S. McCeney M.D.				PHYSICIAN'S NAME (Type) Robert S McCeney MD 402 Main St Laurel Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF May 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Colman Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE Self with Davidson, Laurel, Md.				24a. REC'D BY REGISTRAR DATE MAY 19 60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06111

Reg. Dist. No.

6083

1. PLACE OF DEATH o. COUNTY Prince George Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MARY Middle M. Last MATTINGLY		4. DATE OF DEATH Month MAY Day 20 Year 60	
5. SEX M F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Clerk U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Pomfret, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph H. Mattingly		14. MOTHER'S MAIDEN NAME Mary Clara Maddox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Richard L. Mattingly		Address 4413-17th St. N. Arl. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 days 5yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 27, 19 47, to May 20, 19 60, that I last saw the deceased alive on May 20, 19 60, and that death occurred at 7:17 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Collins M.D.		ADDRESS (Street, city or town, state) DATE SIGNED May 20-60	
PHYSICIAN'S NAME (Type) THOMAS F. COLLINS M.D.		322 - H ST. NE May 20-60	
22a. BURIAL, CREMATION, or other disposition		22b. DATE THEREOF 5-23-60	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's		22d. LOCATION (City, town, or county) (State) Pomfret, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300-4th St. N.E.	
24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Hill</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4707 - Oxon Run Blvd</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Woodlawn</u> d. STREET ADDRESS <u>6620 Newport Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rachel Bryant May</u>			4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 20, 1876</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Francis Wheat</u>				
14. MOTHER'S MAIDEN NAME <u>Henriette Maria Nash</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>4001-427</u>			17. INFORMANT <u>George F May</u> Address <u>4001-427 Washington D.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ </div> <div style="width: 35%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) 		(County) 		(State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>May 13, 1960</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Pr. Geo. Co., Maryland</u>		(State) 					
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>			24a. REC'D BY REGISTRAR <u>MAY 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Deputy Medical Examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
6178 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
06113									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt #4., Mellwood, Md. c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt# 4 Mellwood, Md					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 419 37th Place S.E., Apt 202 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN DILLARD McCOMBS					4. DATE OF DEATH Month May Day 21 Year 1960				
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 23, 1939		9. AGE (in years last birthday) 21 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ADR3 USN		10b. KIND OF BUSINESS OR INDUSTRY *		11. BIRTHPLACE (State or foreign country) Murphy, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min. 21	
13. FATHER'S NAME William Dillard McCombs					14. MOTHER'S MAIDEN NAME Nancy Katherine Hunt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 1956-1960 220-34-9030		17. INFORMANT Mrs. Nancy K. Summerlin, Same as # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 823X IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed skull and chest DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of an automobile that ran off road and struck fixed/				
20c. TIME OF INJURY Month, Day, Year 1:00 PM 5/21 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 4 Mellwood P. G. Md.		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> object	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or County) May 21, 1960				
ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) James I. Boyd			DATE SIGNED May 21, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Va.			
23. FUNERAL DIRECTOR W.W.Ghambers Co.					24a. REC'D BY REGISTRAR MAY 24 '60				
24b. REGISTRAR'S SIGNATURE Charles S. Hunt									

NOV 1960



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Prince George

St. George, N.Y.

St. George, N.Y.

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May 27, 1960

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St. George, N.Y.

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Adasacord Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Ramsay</u> Last <u>McIntosh</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Douglas Ramsay</u>	
14. MOTHER'S MAIDEN NAME <u>MARY DUAL Cowles</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u> </u>	
16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>SISTER</u> Address <u>Francis Munroe Ramsay</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>581.0</u> IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>April 23, 1960</u> to <u>May 4, 1960</u> , that I last saw the deceased alive on <u>May 4, 1960</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat</u> M.D. <u>3503 Penny St</u>		DATE SIGNED <u>5/4/60</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT</u>		<u>MT Rainier Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>may 7, 1960</u>	22b. DATE THEREOF <u> </u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>	22d. LOCATION (City, town, or county) (State) <u>Halls Church Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dafford Funeral Home</u> ADDRESS <u>475-H-NW</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>

VS A1S (4)
15M 9/58

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may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. James Boyd notified p.d.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6179
CERTIFICATE OF DEATH

06115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Florida</i> b. COUNTY <i>Pinellas</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carmody Hills</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St Petersburg</i> 48X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>506 - 73rd Pl.</i>				d. STREET ADDRESS <i>938 - 16th Ave</i>			
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Frankle</i> Last <i>Mc Murray</i>				4. DATE OF DEATH Month <i>5</i> Day <i>19</i> Year <i>1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-28-1907</i>	
9. AGE (In years lost birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hotel business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alexander Mc Murray</i>				14. MOTHER'S MAIDEN NAME <i>Foebel Frankle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>St Petersburg</i> <i>Marion Ann McMurray Wife</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute coronary occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Anteriosclerotic coronary disease</i> 15 yrs DUE TO (c) <i>11 min</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5-19-</i> , 19 <i>60</i> to <i>5-19-</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>5-19-</i> , 19 <i>60</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Peter Duus</i>				ADDRESS (Street, city or town, state) <i>6124 Central Av.</i> DATE SIGNED <i>5-19-60</i>			
PHYSICIAN'S NAME (Type) <i>PETER DUUS</i>				Capitol Heights Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 23, 1960.</i>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <i>St Petersburg, Florida.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home 300-H St. NE Wash DC</i>				ADDRESS <i>Wash DC</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 24 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14 Film G263 5-23-60 et

06116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69 College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5004 Hollywood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cyril Thomas Mc Naughton		4. DATE OF DEATH Month Day Year May 12 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-20-7239	
17. INFORMANT Marjorie McNaughton; same address as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 976X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c) DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour g.m. May 12, 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hollywood Pr. Geo. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED May 13, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Maryland.	
24a. REC'D BY REGISTRAR DATE MAY 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06117

6120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harvey Middle McPherson Last McPherson				4. DATE OF DEATH Month May Day 13 Year 19 60			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-97	
9. AGE (In years lost birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank McPherson				14. MOTHER'S MAIDEN NAME Caroline S. Wilkerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Mary G. Wilkerson				Address Rt.2 Box 62b Waldorf, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Pulmonary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Apr. 14 , 19 60 , to May 13 , 19 60 , that I last saw the deceased alive on May 13 , 19 60 , and that death occurred at 8:30P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE George H. McLaim M.D. 1746 K Street, N.W. PHYSICIAN'S NAME (Type) Dr. George H. McLaim, M.D. Washington, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-17-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Metropolitan Methodist		22d. LOCATION (City, town, or county) Belmont, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Barrett Matthews				ADDRESS 3619-14" St., N.W., Wash, D.C.		24a. REC'D BY REGISTRAR DATE MAY 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms							

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Caroline S. Wilkerson

Harry G. Wilkerson, Rt. 2, Box 10
Carleton, Md.

1. *James H. [illegible]*

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07243

Reg. Dist. No.

7295

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>Deodonaire</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Naylor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deolson Clinic</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Middleton</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1917</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George M. Middleton</u>				14. MOTHER'S MAIDEN NAME <u>Anita Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[blank]</u>		17. INFORMANT <u>Arthur Middleton</u> Address <u>Brandywine Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 4, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Naylor, P. Geo. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Nelson</u>				ADDRESS <u>Aguasco, Md.</u>		24a. REC'D BY REGISTRAR <u>John 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF CHURCH	
19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF INTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
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43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
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49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
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61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
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91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 35 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Brentwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 3807 Allison Street			
3. NAME OF DECEASED (Type or print) First Etta Middle Mae Last Miller				4. DATE OF DEATH Month May Day 21 Year 19 60			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-09		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rodney C. Burdette				14. MOTHER'S MAIDEN NAME Katherine Cramer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0519		17. INFORMANT Geo. C. Hartsock Address 4210 Elizabeth St., Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Gastro enteric hemorrhage (c) Duodenal ulcer stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED May 21, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	
				24a. REC'D BY REGISTRAR MAY 24 '60			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, state execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be retained for 5 years. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John A. Smith		Male		45		Dec 15, 1940	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Clerk		High School		Hypertension		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

(M)
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the coroner and to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06129

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Washington D.C. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 3706 Foote Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Darryl Middle Wayne Last Mills			4. DATE OF DEATH Month May 15 Day Year 19 60		
5. SEX Male	6. COLOR OR RACE Col,	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-56		9. AGE (In years last birthday) 3 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) N. Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Roman Lee Mills			14. MOTHER'S MAIDEN NAME Beatrice Perry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Nora Faison; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of skull and both arms. (c) DUE TO (o), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by automobile			
20c. TIME OF INJURY Month, Day, Year 2.48 Hrs. 5-15-60 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) Jefferson Hts. Pr. Geo. Md.		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5-20-60		22c. NAME OF CEMETERY OR CREMATORY Unknown
22d. LOCATION (City, town, or county) Durham, North Carolina			22e. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Frazier Funeral Home, Inc. 389 R.D. 2nd			24a. REC'D BY REGISTRAR MAY 19 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Frazier
24c. CHIEF MEDICAL EXAMINER John T. Maloney, M.D.			24d. DEPUTY MEDICAL EXAMINER May 16, 1960		

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06121

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Suitland</u>			
c. LENGTH OF STAY IN 1b <u>15.0. a.</u>				d. STREET ADDRESS <u>5611 Shadyside Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marvin Earl Moffett</u>				4. DATE OF DEATH <u>May 14 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 22, 1901</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u>		11. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Arthur Edwin Moffett</u>				14. MOTHER'S MAIDEN NAME <u>Annie Adele Richards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>1918-1921</u>				16. SOCIAL SECURITY NO. <u>5400-AUTH-105</u>			
17. INFORMANT <u>Joseph Arthur Moffett, Wash 23, D.C.</u>				Address <u>5400-AUTH-105</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Bleeding from Carcinomatous area</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>in bronchi</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>5-14-60</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town, or county) <u>Suitland MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland MD</u>	
23. FUNERAL DIRECTOR <u>Simmons Bros.</u> ADDRESS <u>1661-20th Ave SE Wash DC</u>				24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>			
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

1013

X



1



CERTIFICATE OF DEATH

Reg. Dist. No.

06122

6124

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		d. STREET ADDRESS 5511 Parkland Court	
3. NAME OF DECEASED (Type or print) First William Middle Morgan Last Morgan		4. DATE OF DEATH Month May Day 13 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13th, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Morgan		14. MOTHER'S MAIDEN NAME Emma Coates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. Morgan Jr.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia and diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 18 days 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 26, 1959 to May 13, 1960 that I last saw the deceased alive on May 13, 1960 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Cleary		ADDRESS (Street, city or town, state) 5558 Silver Hill Rd.	
PHYSICIAN'S NAME (Type) Thomas F. Cleary		DATE SIGNED 5-13-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas B. Darden		ADDRESS 3831 - Ga. Ave. N.W.	
24a. REC'D BY REGISTRAR DATE MAY 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06123
Reg. Dist. No.

6181

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- Maryland b. COUNTY -- Pri. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN lb 15 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Southern Md. Hospital Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Infant Roger Middle Arthur Last Myers, Jr.		4. DATE OF DEATH Month May Day 30 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1960
9. AGE (In years lost birthday) yrs. 15		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Roger A. Myers, Sr.		14. MOTHER'S MAIDEN NAME Audrey Tayman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
INFORMANT Roger A. Myers, Sr., Cheltenham, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) abruptio Placenta and massive hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 29, 1960 , to May 29, 1960 that I last saw the deceased alive on May 29, 1960 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Santiago Garza, M.D.		DATE SIGNED 5/30/60	
PHYSICIAN'S NAME (Type) Dr. Santiago Garza, M.D.		ADDRESS (Street, city or town, state) 5800 22nd Avenue, Hillcrest Heights, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/31/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JUN 6 '60	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

1916

OFFICE OF THE SECRETARY OF THE ARMY

1818



X

RECEIVED
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JAN 10 1916

Reg. Dist. No. 06124

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews Air Force Base</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF HOSP ANDREWS</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 FEB 07</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIRMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Air Force</u>	
11. BIRTHPLACE (State or foreign country) <u>LEXINGTON, KY.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>CHARLES A. NEVITT</u>		14. MOTHER'S MAIDEN NAME <u>PEARL WIMP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1939-1960</u>		16. SOCIAL SECURITY NO. <u>218-24-7513</u>	
17. INFORMANT <u>Charles A. Nevitt</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 May, 1960</u> to <u>31 May, 1960</u> , that I last saw the deceased alive on <u>31 May, 1960</u> , and that death occurred at <u>1225 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>John Paul F.</u> M.D. <u>USAF HOSPITAL ANDREWS</u>		<u>31 May 60</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT D CARILLI, CAPT USAF (MC)</u>		<u>ANDREWS AIR FORCE BASE, WASHINGTON 25, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 3 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reinoldi Funeral Home</u>		ADDRESS <u>816 N St NE, Wash DC</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5210

23

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6183

CERTIFICATE OF DEATH

06125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEO.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural LAUREL			c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural LAUREL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAMMOND PARKWAY				d. STREET ADDRESS HAMMOND PARKWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First VIOLA Middle ESTHER Last OBER				4. DATE OF DEATH Month MAY Day 28 Year 19 60				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/19/07		
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert H. Janty				14. MOTHER'S MAIDEN NAME Hulda Schoenbeck				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-30-3868		INFORMANT Mr. Harold E. Ober, Hammond Pkwy., Laurel, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO 175.0 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (c), stating the under- lying cause lost. (b) GENERALIZED CARCINOMATOSIS DUE TO CARCINOMA OF OVARY (c) 1 YR.							INTERVAL BETWEEN ONSET AND DEATH 8 Mos. 1 YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 6-8 , 19 59 , to 5-28 , 19 60 , that I last saw the deceased alive on 5-27 , 19 60 , and that death occurred at 6 AM, from the causes and on the date stated above.								
ACTUAL SIGNATURE P. Thorpe				ADDRESS (Street, city or town, state) 409 Columbia Rd				
PHYSICIAN'S NAME (Type) PETER THORPE				DATE SIGNED 5/28/60				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/31/60		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 2 '60		
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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CERTIFICATE OF DEATH

0180

DECEASED
NAME
AGE
SEX
DATE OF BIRTH

DECEASED
NAME
AGE
SEX
DATE OF BIRTH

MAY 18

1910

MAY 18

1910

PLACE OF BIRTH

PLACE OF BIRTH

RESIDENT AT DEATH

CAUSE OF DEATH

DATE OF DEATH

1910

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 20 7-25-60 ams											
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 06126											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax d. STREET ADDRESS 38 Norman Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last Suzanne Elizabeth Opsahl					4. DATE OF DEATH Month Day Year May 16, 1960						
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-38		9. AGE (In years last birthday) 22 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME Harold Eugene Opsahl					14. MOTHER'S MAIDEN NAME Mary Elizabeth H. Duffey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Harold E. Opsahl; same address as # 2.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis 431X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 16, 1960											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 19 MAY 1960		22c. NAME OF CEMETERY OR CREMATORY FAIRFAX MEMORY GARDENS CEMETERY		22d. LOCATION (City, town, or county) ANNANDALE VA.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Arnold Funeral Home 816 H St. N.E. DC.					24a. REC'D BY REGISTRAR DATE MAY 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06127

Reg. Dist. No.

6184

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b 47X-3 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE 1638 R Street, N.W. b. COUNTY Washington, D. C. d. STREET ADDRESS 47X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY E. PEACOCK				4. DATE OF DEATH Month Day Year MAY 1 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-26-1934	
9. AGE (In years last birthday) yrs. 25		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-		10b. KIND OF BUSINESS OR INDUSTRY Gov't. Employees Insurance CO.		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? Non-citizen of U.S.A.	
13. FATHER'S NAME Daniel Minogue				14. MOTHER'S MAIDEN NAME Mary Hartigan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Ernest F. Peacock, 1638 R St., N.W., Wash. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HODGKINS DISEASE 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-21- , 19 58 to 5-1- , 19 60 , that I last saw the deceased alive on 4-30- , 19 60 , and that death occurred at 6:18 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lawrence D. Summerfield M.D. 1400 Branch Ave S.E. PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery, Arlington, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gaudier's Sons Inc. 1756 Pa Ave NW.				24a. REC'D BY REGISTRAR DATE MAY 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

6126

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred First HAWES Middle PETTIT Last		4. DATE OF DEATH MAY Month 3 Day 1960 Year	
5. SEX FEMALE	6. COLOR OR RACE F. W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-95
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 64 Days 7 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY TEXAS	
11. BIRTHPLACE (State or foreign country) TEXAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BRIGHT BUCKNER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT NOELE E. PETTIT		Address 5502 EMERSON ST ROGERS HGHTS, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO 5 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/1 , 19 60 , to 5/3 , 19 60 , that I last saw the deceased alive on 5/3 , 19 60 , and that death occurred at 5:53 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat		ADDRESS (Street, city or town, state) 3503 Bay St.	
PHYSICIAN'S NAME (Type) NORMAN DONAT		DATE SIGNED 5/3/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-6-60	
22c. NAME OF CEMETERY OR CREMATORY WASHINGTON, NATIONAL		22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS Riversdale md	
24a. REC'D BY REGISTRAR MAY 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6127 Item 8 Film 204-6-0-00 el

CERTIFICATE OF DEATH

06129

1. PLACE OF DEATH a. COUNTY MARYLAND Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Tb 8 Hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5801 42nd Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle E. Last Poole		4. DATE OF DEATH Month May Day 30 Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1991/1881		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D. C.			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Taltavull				
14. MOTHER'S MAIDEN NAME Captola Shepherd			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --				
16. SOCIAL SECURITY NO. --			17. INFORMANT Wade H. Osborn Address 3802--Aberdeen St., SE Silver Hill, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cancer of blood DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) i metastasize to pelvis bone DUE TO (c) and of focus to pathologic fracture PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 15, 1960 , to May 30, 1960 , that (I) (we) lost saw the deceased alive on May 30, 1960 , and that death occurred at 3:35 PM on the causes and on the date stated above.					
22a. SIGNATURE Y. S. Bergeman		22b. DATE SIGNED May 30, 1960		22c. PHYSICIAN'S NAME (Type) Dr. T. Bergeman			
22d. ADDRESS 4314 Jackson St. Hyattsville Md		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			
23d. LOCATION (City, town, or county) (State) Suitland Md		24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.					
25a. REC'D BY REGISTRAR DATE JUN 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

6123

63

CERTIFICATE OF DEATH

1. Name of deceased: *John Edward*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15, 1900*

5. Date of death: *Dec 10, 1945*

6. Place of death: *St. Louis, Mo.*

7. Cause of death: *Heart disease*

8. Signature of physician: *Dr. J. H. Smith*

9. Signature of registrar: *Wm. H. Jones*

10. Date of registration: *Dec 15, 1945*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
5M 9/55

Item 18 Form 264-5-60 3-55										06130	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										6149	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Princess Anne Somerset						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale					c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 19X-2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					d. STREET ADDRESS Beckford Avenue 502					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anne Garrison Porter					4. DATE OF DEATH May 1, 1960						
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 23, 1941		9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY University		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Porter					14. MOTHER'S MAIDEN NAME Arenthia Cullen						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-38-1539		17. INFORMANT James Porter; same address as # 2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrocytoma 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John T. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED May 1, 1960	
EXAMINER'S NAME (Type) John T. Maloney, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 5/4/60		22c. NAME OF CEMETERY OR CREMATORY St Andrews			22d. LOCATION (City, town, or county) (State) Princess Anne Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James Harrison					ADDRESS Princess Anne Md.		24a. REC'D BY REGISTRAR DATE MAY 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		MARITAL STATUS [Single/Married/Widowed]		DATE OF DEATH [Date]	
TIME OF DEATH [Time]		PLACE OF DEATH [Place]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Manner]	
SIGNATURE OF MEDICAL EXAMINER [Signature]		SIGNATURE OF DECEASED'S NEAREST RELATIVE [Signature]		SIGNATURE OF DECEASED'S NEXT OF KIN [Signature]		SIGNATURE OF DECEASED'S ATTORNEY [Signature]	
MEDICAL EXAMINER'S CERTIFICATE [Text]		DECEASED'S NEAREST RELATIVE'S CERTIFICATE [Text]		DECEASED'S NEXT OF KIN'S CERTIFICATE [Text]		DECEASED'S ATTORNEY'S CERTIFICATE [Text]	

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06131

6128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 13 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oxen Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 7119 Tucker Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Christppher Eugene First Middle Last				4. DATE OF DEATH May 3 1960 Month Day Year			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 19, 1960	
9. AGE (In years lost birthday) yrs. 13		10. IF UNDER 1 YEAR Months Days Hours Min. 13		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Proctor				14. MOTHER'S MAIDEN NAME Mary Evelyn Savoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None			
17. INFORMANT Mother				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) Prenaturity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 19 1960 to May 3 1960 , that I last saw the deceased alive on May 3 1960 , and that death occurred at 10:45 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Perkins		M.D. 5301 Hamilton St., Hyattsville		DATE SIGNED 5/3/60			
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.		5301 Hamilton St. Hyattsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/4/60		22c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		22d. LOCATION (City, town, or county) (State) Gomfred, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Archard Funeral Home, La Plata		ADDRESS La Plata		24a. REC'D BY REGISTRAR MAY 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

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James T. ...

13 Dec 1951

1115 Jackson Road

Proctor

United States ...

Nov. 15, 1950

London

London

Harry ...

James ...

1951

CONFIDENTIAL

Nov 1 1950

1950

50

Nov 3

2501 Madison Ave. ...

Mr. John ...

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06132	
6185										CERTIFICATE OF DEATH	
										Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)					c. LENGTH OF STAY IN 1b 1 yr., 10 mos., & 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital					d. STREET ADDRESS 1419 1st St., N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ellis Middle G. Last Reed					4. DATE OF DEATH Month 5 Day 14 Year 19 60						
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/01		9. AGE (In years lost birthday) 58 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver					10b. KIND OF BUSINESS OR INDUSTRY Sky King Cab Co.,		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cornelius Reed					14. MOTHER'S MAIDEN NAME Mary ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 578-22-3623		INFORMANT Decedent			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage, acute DUE TO active Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Pulmonary tuberculosis, moderately advanced, / DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 yrs., 2 mos.,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right upper lobectomy & wedge middle lobe, 8/31/59; right thoracoplasty, 11/5/59										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7/2/58 , to 5/14/60 , that I last saw the deceased alive on 5/14/60 , and that death occurred at 10:45 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE Moe Weiss					DATE SIGNED Glenn Dale Hospital 5/14/60						
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					Glenn Dale, Md.						
22a. BURIAL, CREMATION, (REMOVAL) (Specify) Burial					22b. DATE THEREOF 5/14-60		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE Malven T. Schey Inc.					ADDRESS 424 R. St. NW Wash DC		24a. REC'D BY REGISTRAR MAY 19 60		24b. REGISTRAR'S SIGNATURE Quilley S. Howard		

58133

CERTIFICATE OF DEATH

58133

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6186

CERTIFICATE OF DEATH

06133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MONOR - 4922 La Salle Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Shene Middle de B. Last ROBBINS				4. DATE OF DEATH Month MAY Day 8 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28-1987	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 2 Days 10	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Dept.		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		11. BIRTHPLACE (State or foreign country) Buenos Aires, Argentina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Casimiride Bruyn				14. MOTHER'S MAIDEN NAME Mercedes Mantel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		INFORMANT Address Sister Agnes Patricia - 4922 La Salle Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Cerebral embolus DUE TO (c) Thrombus in left atrium							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease with mitral insufficiency							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 5/6 , 19 55 , to 5/8 , 19 60 , that I last saw the deceased alive on 5/6 , 19 60 , and that death occurred at 3:56 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack P. Segal				ADDRESS (Street, city or town, state) 900 17th St. W. W.			
PHYSICIAN'S NAME (Type) JACK P. SEGAL				DATE SIGNED 5/8/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-10-60		22c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) FAIRHAVEN, MASS.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulus Boudier				24a. REC'D BY REGISTRAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10-103

CERTIFICATE OF DEATH

10-103

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Race: *White*
4. Date of birth: *10-10-1920*
5. Date of death: *10-10-1980*
6. Place of death: *Home*
7. Cause of death: *Heart Disease*
8. Manner of death: *Natural*
9. Signature of physician: *Dr. J. Smith*
10. Signature of registrar: *John Doe*

11. Signature of informant: *John Doe*
12. Date of completion: *10-10-1980*
13. Place of completion: *Home*
14. Signature of informant: *John Doe*
15. Date of completion: *10-10-1980*
16. Place of completion: *Home*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6129

CERTIFICATE OF DEATH

Reg. Dist. No.

06134

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 7 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. Prince Georges Charles County	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		g. STREET ADDRESS Rt.2 Box 65 A		h. 08X-2	
3. NAME OF DECEASED (Type or print) First Charles Middle Abraham Last Robinson		4. DATE OF DEATH Month May Day 17 Year 60		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH April 9, 1922		9. AGE (In years lost birthday) yrs. 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Morton Robinson		14. MOTHER'S MAIDEN NAME Mary Agnes Sewell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT		17. ADDRESS 9501 Old Fort Road John O. Robinson, Washington 20, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcinomatosis DUE TO Neurofibrosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Neurofibromatosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 10, 1960 to May 17, 1960 , that I last saw the deceased alive on May 17, 1960 , and that death occurred at 9 A-M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE George Hageage M.D.		PHYSICIAN'S NAME (Type) DR. GEORGE HAGEAGE		22a. REC'D BY REGISTRAR DATE MAY 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1960		22c. NAME OF CEMETERY OR CREMATORY St Marys		22d. LOCATION (City, town, or county) (State) Piscataway, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

6182

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06135

CERTIFICATE OF DEATH

Reg. Dist. No.

6187

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 11 months and 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
		d. STREET ADDRESS 44 Defrees St., N. W.	
3. NAME OF DECEASED (Type or print) First Edith Middle Stokes Last Rollins		4. DATE OF DEATH Month 5 Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Separated, not legally WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/08
9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min.	IF UNDER 24 HRS. Months - Days - Hours - Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) S. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Daniel Stokes		14. MOTHER'S MAIDEN NAME Rena Pough	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) ? Address Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Operative death 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Right upper and middle lobe lobectomies DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active 17 months			INTERVAL BETWEEN ONSET AND DEATH 5/4/60 5/3/60
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/6, 1959, to 5/4, 1960 that I last saw the deceased alive on 5/4, 1960, and that death occurred at 1:37 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 5/4/60 ACTUAL SIGNATURE Moe Weiss, M.D. PHYSICIAN'S NAME (Type) Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/5/60	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cen	22d. LOCATION (City, town, or county) (State) D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros (Mld) 621 Pa. Ave. N.W.		24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE J. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

612

1

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

Handwritten notes at the bottom of the page, possibly indicating the date and location of the death.

06136

CERTIFICATE OF DEATH

Reg. Dist. No.

6130

VS A15 (4)
ISM 9/58

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hesper		4. DATE OF DEATH Month May Day 24 Year 1960	
5. SEX Female		6. COLOR OR RACE W.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-4-08	
9. AGE (In years lost birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William B. Royer		14. MOTHER'S MAIDEN NAME Bertha G. Zepp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: Internal Hemorrhage IMMEDIATE CAUSE (a) Metastatic Carcinoma of Rt. Breast DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 18, 1960 to May 24, 1960 , that I last saw the deceased alive on May 24, 1960 , and that death occurred at 8 p. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2016 Freig St., Seat Pleasant, Md. 5/24/60	
ACTUAL SIGNATURE Max M. Hertzberg		DATE SIGNED 5/24/60	
PHYSICIAN'S NAME (Type) Dr. Max M. Hertzberg MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 27 May '60	
22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR May 31 '60	
ADDRESS 300-4th St. N. E. Wash DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

29

CERTIFICATE OF DEATH

Reg. Dist. No.

06137

6188

1. PLACE OF DEATH a. COUNTY Prince Geo.				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills				c. LENGTH OF STAY IN 1b				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				b. COUNTY Prince Geo.																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3901 72nd Ave.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) First MURRAY				Middle ALLEN				Last SEARS				4. DATE OF DEATH Month May				Day 16				Year 1960															
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 8 April 1894				9. AGE (In years lost birthday) 66 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender								10b. KIND OF BUSINESS OR INDUSTRY Restaurant								11. BIRTHPLACE (State or foreign country) Md.								12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Thomas Sears												14. MOTHER'S MAIDEN NAME Mary S. Jones																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No								16. SOCIAL SECURITY NO. 6								INFORMANT Elizabeth H. Sears- Same 1d- Wife								Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) Carcinoma, bronchogenic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH 3 months																			
																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Oct. 1, 1959 to May 16, 1960 , that I last saw the deceased alive on May 16, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4410-74th Ave. Hyattsville, Md. 5/16/60																																			
ACTUAL SIGNATURE C. D. Connor								M.D. 4410-74th Ave. Hyattsville, Md.																											
PHYSICIAN'S NAME (Type) C. D. Connor								4410 74th Ave. Hyattsville, Md.																											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF 18 May 1960								22c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem.								22d. LOCATION (City, town, or county) (State) Suitland, Md.											
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funera 1 Home 300-4th St. N. E. Wash. DC												24a. REC'D BY REGISTRAR MAY 19 1960												24b. REGISTRAR'S SIGNATURE Carlton S. Fennell											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6182

CELESTIAL C. DEATH

Landover Hills

1301 72nd Ave.

Landover Hills

1301 72nd Ave.

MURRAY

ALLEN

ALLEN

White

White

Restaurant

Restaurant

Thomas Jones

Wm. H. Jones

1111-11th St. N. W. - Room 10-11

no

1111-11th St. N. W. - Room 10-11

1111-11th St. N. W. - Room 10-11

1111-11th St. N. W. - Room 10-11

1111-11th St. N. W. - Room 10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06138

CERTIFICATE OF DEATH

Reg. Dist. No.

6189

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1030 University Blvd. East.</u>				d. STREET ADDRESS <u>1030 E. Univ Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John L Segall</u> First Middle Last				4. DATE OF DEATH <u>May 1 1960</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1885</u> 75 yrs.		9. AGE (In years lost birthday) IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Boston Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Segall</u>				14. MOTHER'S MAIDEN NAME <u>Bertha LaPatte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Ruth P Segall</u> Address <u>Daughter</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>20 years</u> (c) <u>generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia rt. due to CVA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1957</u> to <u>5-1-1960</u> , that I last saw the deceased alive on <u>4-30-1960</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Peter Rivers</u> M.D.				DATE SIGNED <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>PETER RHUS</u>				<u>Capitol Heights Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church</u>		22d. LOCATION (City, town, or county) (State) <u>Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky & Sons</u> ADDRESS <u>3501-14th St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

6131

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Seltzer Last Seltzer				4. DATE OF DEATH Month May Day 17 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 April 1906	
9. AGE (In years lost birthday) yrs. 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Seltzer				14. MOTHER'S MAIDEN NAME Lenora Facer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. 579-01-3286		17. INFORMANT Address Emma A. Seltzer (Wife) Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary emboli with pulmonary infarction. DUE TO (b) Periparturient venous thromboses. DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute pericarditis and pleuritis @ Carcinoid tumor of jejunum							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from Feb. 1960, to 5-17- 1960, that I lost saw the deceased alive on 5-16- 1960, and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Peter Duus M.D. PHYSICIAN'S NAME (Type) Dr. Peter Duus, M.D.				SEAT PLEASANT, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/20/60		22c. NAME OF CEMETERY OR CREMATORY Ceder Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE MAY 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Klaus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1000 01-01-01

100108

11-35502

(117) 1985-10-10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 9 Film 264 6-3-60 at
6150
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

06140

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD-</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>63 Edmanston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hospital</u>		d. STREET ADDRESS <u>5107 Emerson St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>W.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-'80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Port Printing Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mayor E. Sumwalt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hospital Record-</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.D. - Hypertension Diabetes Mellitus</u>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11.</u> p. m. <u>San 31</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , to <u>5-22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>60</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.R. Purdie</u>		ADDRESS (Street, city or town, state) <u>Riverdale Md</u>	
PHYSICIAN'S NAME (Type) <u>D.R. PURDIE</u>		DATE SIGNED <u>May 22/1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville, Maryland.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 47		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3120-Powder Mill Road		d. STREET ADDRESS 3303-Bunker Hill Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa Ellen Smith		4. DATE OF DEATH May 9th 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY IN OWN HOME	
11. BIRTHPLACE (State or foreign country) BERKELEY CO. W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.-A.	
13. FATHER'S NAME DENTON SHRIVER		14. MOTHER'S MAIDEN NAME ANNA ELIZABETH COURTNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. C. Robt. Wallace Jr.		Address #5-Glenmullen Place ALEXANDRIA, VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 420.10 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 1 week 15 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1952 to May 9, 1960, that I last saw the deceased alive on May 8, 1960, and that death occurred at 11:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon L Gallin		ADDRESS (Street, city or town, state) 7206 Colesville Rd.	
PHYSICIAN'S NAME (Type) Leon L Gallin M.D.		DATE SIGNED W. Hyattsville Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 12, 1960	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home		24a. REC'D BY REGISTRAR DATE MAY 13 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1181

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF DEATH

6803

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Date of registration

51

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6190

06143

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 2 months and 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 427 6th St., S. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle E. Last Soper				4. DATE OF DEATH Month 5 Day 31 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/25/87	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -		11. IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Unemployed) unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William B. Soper				14. MOTHER'S MAIDEN NAME Anna O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-09-8150		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right coronary thrombosis, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Severe coronary arteriosclerosis DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far advanced pulmonary tuberculosis, active (4 yrs., 4 months); diabetes mellitus; chronic pyelonephritis; pulmonary edema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/21 1960 to 5/31 1960 , that (I) (we) last saw the deceased alive on 5/31 1960 , and that death occurred at 11:26 A. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 5/31/60			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. CREMATION, REMOVAL (Specify) -		23b. DATE THEREOF 6/1/60		23c. NAME OF CEMETERY OR CREMATORY Washington, D. C.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE R. G. Mattingly				25a. REC'D BY REGISTRAR DATE JUN 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

6190

CHARTER OF DATA

0013



Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution had residence after admission) a. STATE		b. COUNTY	
Prince Georges				Maryland		Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cheverly		5 min.		02 Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				1 d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince Georges General				Gunpowder Rd.			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		Hester		L.		Spicknell	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		b. DATE OF BIRTH	
Female		White				April 27, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		9. AGE (In years last birthday) yrs.	
Housewife		own home		Maryland		77	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Thomas B. Jones		Moranda Talbott					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
no		none		Harrison Spicknell		Beltsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteroseptal heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED	
				Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3-1-1946, to May 10, 1960 that I last saw the deceased alive on May 10, 1960, and that death occurred at 11:05 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. Reetz M.D. Hyattsville, Md. 5/16/60 4314 Gallatin Street Hyattsville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 12, 1960		George Washington		Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons		Hyattsville, Maryland		DATE MAY 16 '60		Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

6133
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06145

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE Penna. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Red Lion, Pa.		75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 424 S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle B. Last Stein				4. DATE OF DEATH Month May Day 31 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-86	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) York County, Pa	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME James Wilson		14. MOTHER'S MAIDEN NAME Martha Criswell		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Davis		Address 3809-39th St. Brentwood, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 202.1 Lymphoma, generalized DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 5/2 1960 to 5/31 1960, that (I) (we) last saw the deceased alive on 5/31 1960, and that death occurred 8:05 PM from the causes and on the date stated above.		22a. SIGNATURE Norman Donat Comeau M.D. 22b. DATE SIGNED 5/31/60	
22c. PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU MD		22d. ADDRESS 3503 PENNYST MT RAINIER MD		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/60	
23c. NAME OF CEMETERY OR CREMATORY Red Lion Cemetery		23d. LOCATION (City, town, or county) (State) Red Lion, York Co., Pa.		24. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE JUN 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

(M)

Red Lion

(1)



6191

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Gep.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek				c. LENGTH OF STAY IN 1b 8 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 45				e. STREET ADDRESS Box 45--			
3. NAME OF DECEASED (Type or print) First ALVIN Middle O. Last STEWART				4. DATE OF DEATH Month May Day 31 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5th 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Doc B. Stewart				14. MOTHER'S MAIDEN NAME Gora Elkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Bertha A. Stewart (Wife) Address Accokeek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) THROMBOSIS OF FEMORAL ARTERIES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 1 DAY YRS 3 YRS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 14th, 1956 , to May 31th, 1960 , that I last saw the deceased alive on May 31th, 1960 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Accokeek, Md., May 31th, 1960 DATE SIGNED							
ACTUAL SIGNATURE Paul Chen				M.D. Accokeek, Md., May 31th, 1960			
PHYSICIAN'S NAME (Type) PAUL CHEN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons B.W.				ADDRESS 1661--Good Hope RD SE Wash. 20 DC		24a. REC'D BY REGISTRAR JUN 2 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. House			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06147

6086

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD.</u>		c. LENGTH OF STAY IN 1b <u>60</u> <u>NYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR-4922 PASADENA RD.</u>		d. STREET ADDRESS <u>1 5800 MARYHURST DR.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>M.</u> Last <u>STEWART</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>	11. IF UNDER 24 HRS. Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Willard Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Weismuller</u>		14. MOTHER'S MAIDEN NAME <u>DORA O'CONNOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>yes ?</u>	
17. INFORMANT <u>Sister Agnes Patricia</u>		Address <u>4922 Pasadena</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 15, 1959</u> to <u>May 7, 1960</u> that I last saw the deceased alive on <u>May 6, 1960</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis P. Hannan</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1511-17 St. N. W. Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/10/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Heave Co.</u>		24a. REC'D BY REGISTRAR <u>WASH D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>WASH D.C.</u>		DATE <u>MAY 9 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8803

CERTIFICATE OF DEATH

1911

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
See: Birth Cert. et
6134
CERTIFICATE OF DEATH

06148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 3 Hr 45 Min d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Route 3 Box A 80-A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Swann Middle -- Twin I Last Baby Girl		4. DATE OF DEATH Month May Day 6 Year 1960	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6 1960	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 45 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard A. Swann		14. MOTHER'S MAIDEN NAME Jacqueline Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Osteoarthritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 60 , to May 6 , 19 60 , that I last saw the deceased alive on May 6 , 19 60 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6901 Baltimore Ave, College Park, Md. DATE SIGNED May 6, 1960			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/19/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR DATE MAY 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

2177192X40

6134

X

(C)

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY

WASHINGTON, D. C.

May 10, 1917

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 5th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Yours very truly,

W. L. RORER, Assistant Secretary.

Very truly yours,

W. L. RORER

cc - Mr. [illegible]

cc - Mr. [illegible]

cc - Mr. [illegible]

cc - Mr. [illegible]

cc - Mr. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS-A15 (4)
15M/9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert. et

CERTIFICATE OF DEATH

Reg. Dist. No.

06149

6135

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 Hr 45 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Route 3 Box A 80-A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy		First (Twin II)		Last Swann		4. DATE OF DEATH Month May	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1960	
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 45		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Richard A. Swann				14. MOTHER'S MAIDEN NAME Jacqueline Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		INFORMANT Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Apnea DUE TO (c) Apnea				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 6, 1960 , to May 6, 1960 , that I last saw the deceased alive on May 6, 1960 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 Baltimore Ave. College Park, Md. DATE SIGNED May 6, 1960							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				PHYSICIAN'S NAME (Type) Dr. Thomas A. Christensen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 5/19/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator				24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

22/77193XV10

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove enclosed papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
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6136

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06150

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 4024 36th St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CARL N. THOMAS SR.				4. DATE OF DEATH Month MAY Day 31 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/95	
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint contractor				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gideon A. Thomas				14. MOTHER'S MAIDEN NAME Virginia Darnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-10-7150			
17. INFORMANT 8603 21st Place Lester G. Thomas Adelphi Hills, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS				INTERVAL BETWEEN ONSET AND DEATH 11 HRS 1 MONTH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 1 1968 to MAY 31 1960, that (I) (we) last saw the deceased alive on MAY 31 1960 and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Samuel J. N. Sugar				22b. DATE SIGNED May 31, 1960			
22c. PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR				22d. ADDRESS 4300 KAYWOOD DR. MT RAINIER			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 6/3/60			
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery				23d. LOCATION (City, town, or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE She S. H. Kinn Co 2901 14th St N.W. D.C.				25a. REC'D BY REGISTRAR DATE JUN 2 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kinn							

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may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

06151

6143

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Pr. George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>709 Main St</i>		d. STREET ADDRESS <i>709 Main St</i>	
3. NAME OF DECEASED (Type or print) <i>Maurice Augustus Thompson</i>		4. DATE OF DEATH <i>May 25 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 11, 1897</i>
9. AGE (In years lost birthday) <i>62</i> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>general mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US Government</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin Howard Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Molly Sullivan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>1-100-100000</i>	
17. INFORMANT <i>Mrs Audrey Lanos, Laurel Md</i>		Address <i>Laurel Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral Hemorrhage</i> DUE TO (b) <i>Hypertension.</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) <i>Hypertension.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Idolo Pierandrei</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>IDOLO PIERANDREI</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 27, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Remond Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Calmar Manor Md</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Connelton</i>		25a. REC'D BY REGISTRAR <i>MAY 31 '60</i>	
ADDRESS <i>Laurel, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

6192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 3 yrs., 4 months, and 1 day		d. STREET ADDRESS 1008 C. St., N. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Otho James Thrift		4. DATE OF DEATH Month Day Year 5 5 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/14
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Operator		10b. KIND OF BUSINESS OR INDUSTRY Capital Transit	
11. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chas. H. Thrift		14. MOTHER'S MAIDEN NAME Louise Luttrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-14-3433	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Pulmonary tuberculosis, far advanced, active 13 yrs.. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8-rib thoracoplasty, right, 7/48			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1, 1957, to 5/5, 1960, that I last saw the deceased alive on 5/5, 1960, and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss, M. D. Glenn Dale Hospital 5/5/60 PHYSICIAN'S NAME (Type) Wash. National Cem. Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5-7-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Chamber Co		24a. REC'D BY REGISTRAR DATE MAY 9 '60	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



IN SENATE,
January 1, 1912.

REPORT
OF THE
COMMISSIONER OF
THE LAND OFFICE,
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE,
MAY 1, 1911.

ALBANY:
J. B. LEECH, JR.,
PRINTERS,
1912.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06153

Reg. Dist. No.

6137

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Lanham		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 17501 Finn's Lane			
3. NAME OF DECEASED (Type or print) Otto First Herman Middle Tille Last				4. DATE OF DEATH May 3, 1960 Month 3 Day 19 Year			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1890		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired supervisor		10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Tille				14. MOTHER'S MAIDEN NAME Minnie Golditz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Lillian Tille; same address as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) </div>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED May 3, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/6/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR DATE MAY 9 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

IN MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06154

6193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS, WASH 25, DC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DANA BLAKE (ELLEN) VILLYARD		4. DATE OF DEATH Month Day Year MAY 8 1960	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 FEBRUARY 1919
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME MACK BLAKE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WAC (RESERVE) 1953-1956		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HUSBAND		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) L IPO SARCOMA 1979 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 MARCH, 1960, to 8 MAY, 1960, that I last saw the deceased alive on 8 MAY, 1960, and that death occurred at 1205 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harlan S. Parks		ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS DATE SIGNED 8 MAY 1960	
PHYSICIAN'S NAME (Type) HARLAN S PARKS, CAPT USAF MC		ANDREWS AIR FORCE BASE, WASHINGTON 25, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 10, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Rudolph J. Jones		24a. REC'D BY REGISTRAR DATE MAY 11 '60	
ADDRESS 816 N. H. E. Jones		24b. REGISTRAR'S SIGNATURE Charles S. Jones	

CERTIFICATE OF DEATH

1933



From birth the child of the deceased was
 known to the family as the child of the deceased

6194

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tuxedo		c. LENGTH OF STAY IN lb 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2409 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA First A Middle WALSH Last		4. DATE OF DEATH Month MAY Day 22 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 014-24-2856	
17. INFORMANT Vincentine M. Pickett		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OVARIAN CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 Apr, 1960, to 22 May, 1960, that I last saw the deceased alive on 19 May, 1960, and that death occurred at 8:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney		DATE SIGNED 22 May	
PHYSICIAN'S NAME (Type) THOMAS G. MALONEY		ADDRESS (Street, city or town, state) 4814-71st Ave Landover Hills MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/60	
22c. NAME OF CEMETERY OR CREMATORY St. Michael		22d. LOCATION (City, town, or county) (State) Springfield, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE May 25 '60	
24b. REGISTRAR'S SIGNATURE Charles E. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

VS A15 (4)
15M 10/57

43

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06156

6138

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle C Last Watts		4. DATE OF DEATH Month May Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Oct. 1959
9. AGE (In years last birthday) 6 mo		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William C. Watts		14. MOTHER'S MAIDEN NAME Nancy R. Reid	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT William C. Watts		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Pneumonia bilat Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1959 to MAY 21, 1960 that I last saw the deceased alive on MAY 20, 1960 , and that death occurred at 7:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8001 Cheverly Ave, Cheverly, Md. DATE SIGNED Dr. Van Gelderan			
ACTUAL SIGNATURE Dr. Van Gelderan M.D. 8001 Cheverly Ave, Cheverly, Md.			
PHYSICIAN'S NAME (Type) Dr. Van Gelderan M.D.			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 5/24/60	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Church		22d. LOCATION (City, town, or county) (State) Lexington Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR MAY 24 60		24b. REGISTRAR'S SIGNATURE Arthur L. House	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1132

James Douglas

1 day

James Douglas General Hospital

David

C

Malin

23 Oct. 1982

Malin

James A. Kohn

William C. White

Worms

William C. White

21

20

James Douglas

James Douglas

20714 24 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06157

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt Md.				c. LENGTH OF STAY IN 1b 67 Greenbelt, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 C Parkway				d. STREET ADDRESS 23 C Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Arthur Carl Wellman		First Middle Last		4. DATE OF DEATH May 18, 1960		Month Day Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/1885		
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		
10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany				
13. FATHER'S NAME Arthur Etzard Wellmann				14. MOTHER'S MAIDEN NAME Gottfriede Garz				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 058-28-6130		17. INFORMANT Helene Wellmann Greenbelt, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 10, 1960 to May 17, 1960 that I last saw the deceased alive on May 10, 1960 and that death occurred at 2:30 A.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Hans Wodak		M.D. 9-E PARKWAY, GREENBELT, MD.		DATE SIGNED 5-18-60		ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type) Hans Wodak		9 E Parkway Greenbelt, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR MAY 23 '60		
24b. REGISTRAR'S SIGNATURE Arthur J. Frank				DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6195 **CERTIFICATE OF DEATH**

06158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Md. Medical Center</u>				d. STREET ADDRESS <u>Route 3 - Box 335</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L.</u> Last <u>WHITE</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1st 1913</u>	9. AGE (In years last birthday) <u>47</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Daniel Buckler</u>				14. MOTHER'S MAIDEN NAME <u>Burdie Buckler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Randolph C. White - Route 3 - Clinton MD</u>		Address <u>Box 335</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion, superimposed upon a chronic congestive heart failure</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Secondary Cor's dilatation of failure due to</u> DUE TO <u>Acute congestion (April)</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>48</u> , to <u>May 28</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>May 28</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Kastner</u>				ADDRESS (Street, city or town, state) <u>3900 Southern Ave SE, Wash DC</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD H. KASTNER</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Clinton MD</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>				24a. REC'D BY REGISTRAR <u>1661 - Good Hope Rd SE</u> ADDRESS <u>WASH 20 D</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

6196

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 11 months & 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 20 H. St., N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Wiley				4. DATE OF DEATH Month Day Year 5 2 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/20/02	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. - - - -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wiley				14. MOTHER'S MAIDEN NAME Julia Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 709-12-4809		INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525X Acute cor pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary fibrosis and emphysema DUE TO (c) Pulmonary tuberculosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, 7 yrs., bilateral, bronchiectasis							INTERVAL BETWEEN ONSET AND DEATH 7 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/27, 1959, to 5/2, 1960, that I last saw the deceased alive on 5/2, 1960, and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 5/2/60 ACTUAL SIGNATURE Moe Weiss, M. D. M.D. Glenn Dale, Md. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/4/60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Stewart 304, at NE.				24a. REC'D BY REGISTRAR DATE MAY 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0130



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6089

CERTIFICATE OF DEATH

06160

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2703-Queens Chapel Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Mt. Rainier</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>L.</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27/11</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <u>Foundry Chipper Washington Navy Yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Portsmouth Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>598-543337</u>	
17. INFORMANT <u>Nannie L. Williams</u> Address <u>above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>58</u> , to <u>May 24</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>May 21</u> , 19 <u>60</u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.B. Washington</u>		ADDRESS (Street, city or town, state) <u>6234 Ga. Ave NW, Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>D. B. Washington M.D.</u>		DATE SIGNED <u>5/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalleys Funeral Home</u>		ADDRESS <u>Mt. Rainier Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2080

(M)

48

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6087

CERTIFICATE OF DEATH

06161
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601 40th avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise Katherine Willis		4. DATE OF DEATH May 11, 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick I Imhof		14. MOTHER'S MAIDEN NAME Mrs ? Crismond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leslie H Willis		Address Hyattsville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 5-11 , 19 58 , to 5-11 , 19 60 , that I last saw the deceased alive on 5-11 , 19 60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5432 QUEENS CHAPEL Rd DATE SIGNED 5/12/60 ACTUAL SIGNATURE Ronald S. Fleischer M.D. PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER HYATTSTVILLE Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 13, 1960	22c. NAME OF CEMETERY OR CREMATORY Fairfax Cemetery	22d. LOCATION (City, town, or county) (State) Fairfax Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Address Hyattsville, Maryland.		24a. REC'D BY REGISTRAR MAY 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

082

16

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>		<p>4. Date of birth</p>		<p>5. Place of birth</p>	
<p>6. Date of death</p>		<p>7. Place of death</p>		<p>8. Cause of death</p>		<p>9. Manner of death</p>		<p>10. Signature of physician</p>	
<p>11. Signature of registrar</p>		<p>12. Signature of informant</p>		<p>13. Signature of witness</p>		<p>14. Signature of funeral director</p>		<p>15. Signature of undertaker</p>	
<p>16. Signature of coroner</p>		<p>17. Signature of jury</p>		<p>18. Signature of jury</p>		<p>19. Signature of jury</p>		<p>20. Signature of jury</p>	
<p>21. Signature of jury</p>		<p>22. Signature of jury</p>		<p>23. Signature of jury</p>		<p>24. Signature of jury</p>		<p>25. Signature of jury</p>	
<p>26. Signature of jury</p>		<p>27. Signature of jury</p>		<p>28. Signature of jury</p>		<p>29. Signature of jury</p>		<p>30. Signature of jury</p>	
<p>31. Signature of jury</p>		<p>32. Signature of jury</p>		<p>33. Signature of jury</p>		<p>34. Signature of jury</p>		<p>35. Signature of jury</p>	
<p>36. Signature of jury</p>		<p>37. Signature of jury</p>		<p>38. Signature of jury</p>		<p>39. Signature of jury</p>		<p>40. Signature of jury</p>	
<p>41. Signature of jury</p>		<p>42. Signature of jury</p>		<p>43. Signature of jury</p>		<p>44. Signature of jury</p>		<p>45. Signature of jury</p>	
<p>46. Signature of jury</p>		<p>47. Signature of jury</p>		<p>48. Signature of jury</p>		<p>49. Signature of jury</p>		<p>50. Signature of jury</p>	
<p>51. Signature of jury</p>		<p>52. Signature of jury</p>		<p>53. Signature of jury</p>		<p>54. Signature of jury</p>		<p>55. Signature of jury</p>	
<p>56. Signature of jury</p>		<p>57. Signature of jury</p>		<p>58. Signature of jury</p>		<p>59. Signature of jury</p>		<p>60. Signature of jury</p>	
<p>61. Signature of jury</p>		<p>62. Signature of jury</p>		<p>63. Signature of jury</p>		<p>64. Signature of jury</p>		<p>65. Signature of jury</p>	
<p>66. Signature of jury</p>		<p>67. Signature of jury</p>		<p>68. Signature of jury</p>		<p>69. Signature of jury</p>		<p>70. Signature of jury</p>	
<p>71. Signature of jury</p>		<p>72. Signature of jury</p>		<p>73. Signature of jury</p>		<p>74. Signature of jury</p>		<p>75. Signature of jury</p>	
<p>76. Signature of jury</p>		<p>77. Signature of jury</p>		<p>78. Signature of jury</p>		<p>79. Signature of jury</p>		<p>80. Signature of jury</p>	
<p>81. Signature of jury</p>		<p>82. Signature of jury</p>		<p>83. Signature of jury</p>		<p>84. Signature of jury</p>		<p>85. Signature of jury</p>	
<p>86. Signature of jury</p>		<p>87. Signature of jury</p>		<p>88. Signature of jury</p>		<p>89. Signature of jury</p>		<p>90. Signature of jury</p>	
<p>91. Signature of jury</p>		<p>92. Signature of jury</p>		<p>93. Signature of jury</p>		<p>94. Signature of jury</p>		<p>95. Signature of jury</p>	
<p>96. Signature of jury</p>		<p>97. Signature of jury</p>		<p>98. Signature of jury</p>		<p>99. Signature of jury</p>		<p>100. Signature of jury</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

6197

CERTIFICATE OF DEATH

Reg. Dist. No.

06162

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>Minerva</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-67</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Patent Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Magruder</u>		14. MOTHER'S MAIDEN NAME <u>Susan Evelyn Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Self</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u> DUE TO (c) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>over 10 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 7</u> , 19 <u>57</u> , to <u>May 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 9</u> , 19 <u>60</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Louis M. Jimal</u> M.D. <u>4008 Bladenbury Rd. College City, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>LOUIS M JIMAL</u>		College City Md -	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

